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MEDIGAP: STATE RESPONSES TO PROBLEMS WITH HEALTH INSURANCE FOR THE ELDERLY

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DRAWINGS BY JERRY MILLER

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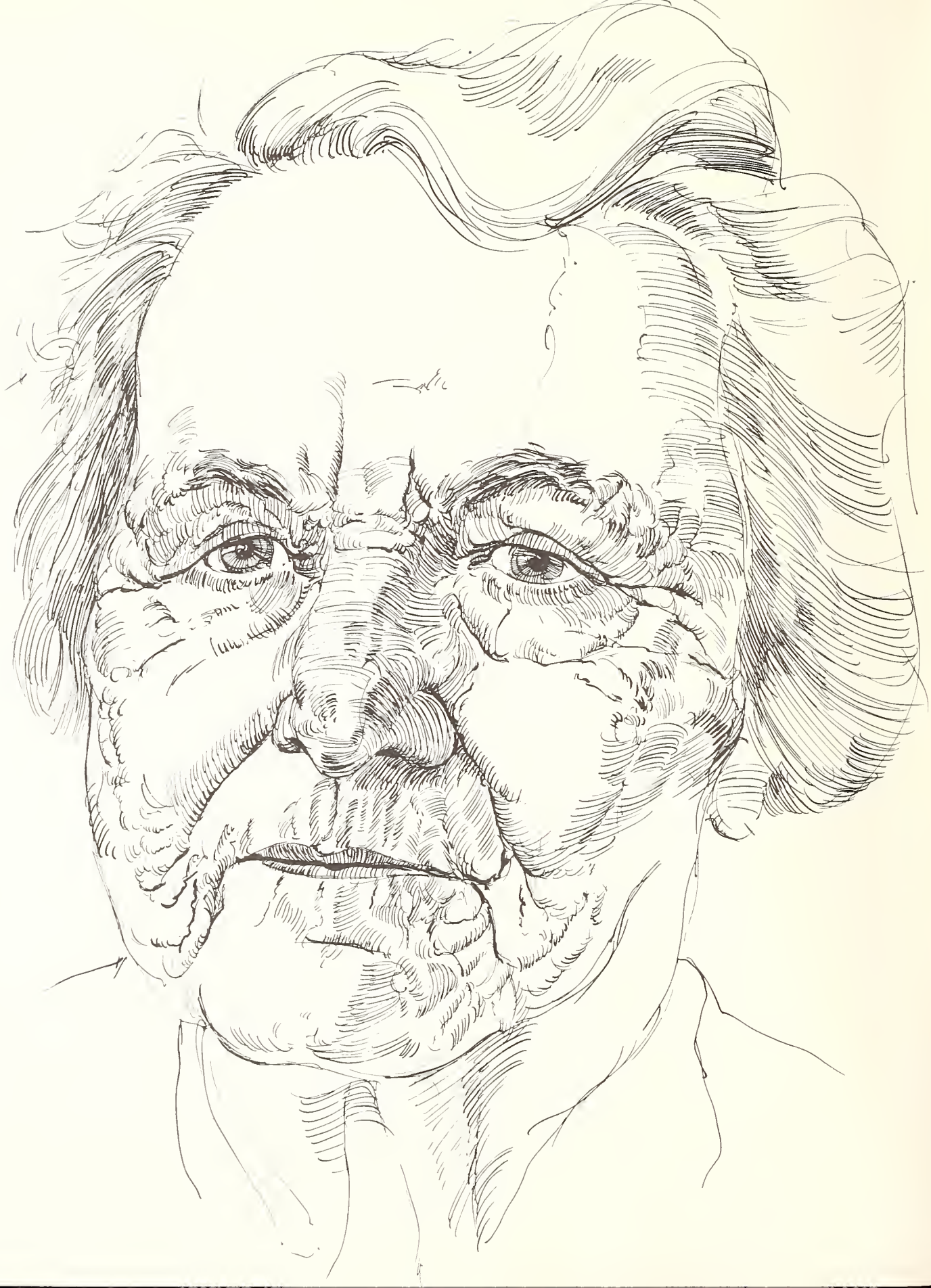


I. INTRODUCTION

The rising cost of medical care causes enormous problems for both providers and consumers using the health care system. No segment of the population, however, is more adversely affected by pervasive and persistent inflationary pressures than the nation's elderly.

Although the aged represent only about 10 percent of the population, they are responsible for over 25 percent of all personal health expenditures.[1] In addition, those over 65 pay more out of pocket for their medical care today than they did in 1965 when the Medicare program was founded. From a high of 50 percent (1969), Medicare now pays for only 38 percent of the total medical bill of the nation's senior citizens.[2] The rest of these expenses are paid either directly by the elderly patient, by various publicly financed medical assistance programs such as Medicaid, or by private health insurance.

Medicare was never designed to cover the total cost of providing medical care for the aged population. As it evolved through the legislative and policymaking process in the 1960s, Medicare assumed many of the characteristics of private health insurance at that time, focusing on the payment of medical bills during periods of acute illness. Medicare, however, was intended to serve as a core health insurance program which the elderly poor could augment with Medicaid; other senior citizens, depending on their needs and resources, could augment Medicare through private health insurance.

The private health industry has been most successful in designing and marketing policies which supplement the coverage provided by Medicare. The acknowledged need for these policies has been fostered by a number of factors, especially the complex and often inadequate benefit structure of the Medicare program itself. Confused by the "gaps" in Medicare coverage and fearful of the financial hardships of poor health, the elderly have turned in increasing numbers to private health insurance for protection and peace of mind. In 1977, approximately 66 percent of the elderly population—15 million of the nation's 23 million senior citizens—had at least one health insurance policy to supplement their Medicare benefits.[3] It is the problems surrounding the sale of Medicare supplements and other forms of private health insurance sold to the elderly that is commonly referred to as the "Medigap" problem.

Unfortunately, a small segment of the insurance industry has exploited the needs and fears of the elderly and the relatively unrestricted nature of the health insurance marketplace. At least twenty-three percent of those who purchase Medicare supplements are thought to have some unnecessary insurance coverage.[4] Some policies duplicate insurance already in force and, therefore, don't pay in times of illness; others, even when they pay, are so inadequate that they offer no real financial protection to the policyholder. In addition, most private health insurance offers little in the way of *new* or *expanded* benefits. Rather, these policies cover only the basic financial gaps for those services *already* covered by Medicare.

With an estimated 19 million insurance policies in force and assuming an average premium cost of $200 per policy, the elderly spent about four billion dollars on health insurance in 1978.[5] Considering one-third of the elderly are near or below the poverty line and most are on fixed incomes, that is a great deal of money for insurance protection, much of which is of questionable utility and quality. The financial drain on the over 65 population—those who can least afford it—is staggering.

Increasingly, federal and state officials and representatives of the private health insurance industry are becoming aware of the Medigap problem. Regulation of the industry is, however, almost exclusively the responsibility of the states. The McCarran-Ferguson Act of 1945 generally immunizes the "business of insurance" from the Sherman, Clayton and the Federal Trade Commission (FTC) Acts to the extent that the industry is regulated by state law. Recent Congressional hearings (which focused on the sale of private health insurance to the elderly), and other activities by the Department of Health, Education and Welfare (DHEW) and the FTC indicate a heightened and ongoing federal interest in possible direct regulation of the health insurance marketplace.

Several bills (S. 395, H.R. 165, H.R. 2602) have been

introduced in the 96th session of Congress to address some of the problems surrounding the marketing of Medicare supplements. Generally, the proposed legislation would increase the Federal government's role in monitoring and controlling the private health insurance marketplace. For example, H.R. 2602, the Senior Citizens Health Insurance Reform Act of 1979, would require the Secretary of DHEW to establish minimum federal insurance standards for Medicare supplement policies. DHEW also would be responsible for certifying all policies sold to the elderly that meet these standards.

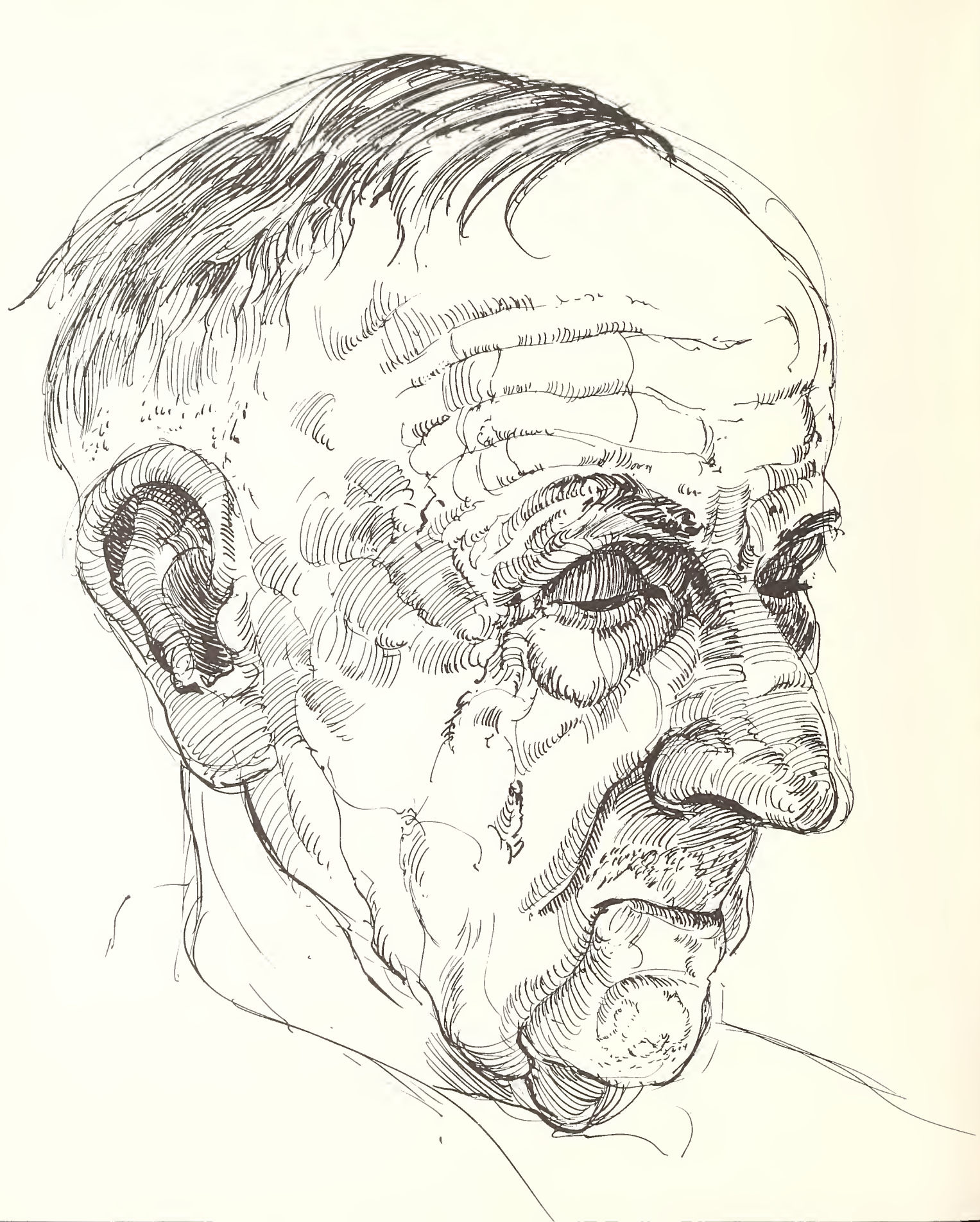
What are the state governments doing to meet this challenge? So far, several states, notably Wisconsin and California, have taken fairly comprehensive steps to curb Medigap abuses. Other states, including Colorado, Illinois, New Mexico and Oregon, have taken a more limited approach to dealing with the irregularities in the private health insurance marketplace. Meanwhile, more states are known to be taking positive action to further regulate the sale of Medicare supplements. Most legislative and regulatory efforts at the state level, however, have been limited in scope and do not yet provide the elderly with full protection.

In 1978, the National Association of Insurance Commissioners (NAIC) established a task force to study the marketing of health insurance to the elderly. As a result of the study, the NAIC adopted model regulations in 1979 to help state officials and legislators address this most complex problem. It remains to be seen whether the "model" is adequate or will be widely used by the states to come to grips with the key issues and policy decisions requiring attention. It is now up to each state to ascertain the severity of Medigap abuses within its own jurisdiction and to develop an appropriate and effective legislative or regulatory program.

It should be noted that although interest in this subject is growing, immediate resolution of Medigap problems seems improbable. There continues to be a pronounced lack of information on the subject—at both the federal and state levels. Also, states vary considerably in their perceptions of the problem and in their capacity and resolve to deal with it in an effective manner.

Strengthened insurance statutes and regulations are not the total answer to eliminating Medigap abuses. States must also take aggressive action to fully enforce the regulations once they are in place.

A survey of states' insurance departments by IHPP staff substantiated the fact that state officials are cognizant of the pressures and problems confronting them on the Medicare supplement issue. They realize that their success (or lack of success) in correcting Medigap abuses is coming under increasing scrutiny by the public and the federal government. Undoubtedly, the ability of the states and the private health insurance industry to resolve the Medicare supplement problem will be considered as Congress evaluates various proposals that would preserve a role for state governments under national health insurance.



II. THE ELDERLY & MEDICARE

Because the structure of the Medicare program has contributed significantly to what has become known as the "Medigap" problem, any explanation of Medigap abuses must first start with a look at Medicare. This federal insurance program consists of two parts. Part A, the Hospital Insurance component, helps the elderly pay for inpatient hospital care, for a limited amount of care in a skilled nursing facility (SNF) certified by the Medicare program, and for some forms of home health care. Part B, the Supplementary Medical Insurance Program, helps pay for physicians fees and for some out-patient and other non-hospital services. Almost all (97%) of the nation's senior citizens are covered by the Hospital Insurance Program while a slightly smaller number (95%) elects to participate in the voluntary Part B program.[6] Part A and Part B both contain certain cost-sharing provisions such as deductibles and coinsurance payments. Table 2 at the end of this chapter summarizes the cost and benefits of both programs.[7]

Medicare has been a valuable resource for the nation's elderly, particularly because the elderly require more medical care than other age groups. For example, those persons over 65 are hospitalized at two and one-half times the rate for persons under the age of 65. In addition, their average length of stay in a hospital is almost two times that of other age groups.[8]

Despite increased federal spending for both Medicare and Medicaid, a growing number of senior citizens have found the insurance program flawed and inadequate and, as a result, have turned to private health insurance for protection. The nation's elderly appear to turn to private health insurance for several reasons. For example, senior citizens now must pay an increasing portion of their limited income to participate in the Medicare program. In addition, with the rapid, excessive growth in the cost of medical care, Medicare covers less and less of the elderly's total health bill. Finally, medical services reimbursed by Medicare are limited and leave many important "gaps" in needed coverage. Medicare is geared more toward episodic, short-term, acute illness rather than the chronic, long-term disorders prevalent in the elderly population. Therefore, many of the greatest needs of the elderly, such as custodial care, dental care, and eye care, are not covered at all. The following sections briefly elaborate on some of the many deficiencies in the Medicare program.

INCREASING COST-SHARING PROVISIONS

Because of statutory provisions in the Social Security Act, Medicare cost-sharing requirements are adjusted annually to help offset the increased costs of providing medical care. The use of these cost-sharing requirements is believed necessary to prevent over-utilization of the health care system and to protect the fiscal integrity of the Medicare program. However, such requirements have risen much faster than the cost-of-living increases provided to the elderly by the Social Security program. Table 2 presents information which summarizes some of the increasing costs of the Medicare program.[9]

TABLE 1
Medicare Premium Costs, Deductibles and Coinsurance Rates 1966 and 1979

Cost-Sharing Requirement	Cost 1966	Cost 1979	Difference	Percent Difference
Hospital insurance deductible (Part A)	$40	$160	$120	300
Hospital coinsurance (61st-90 days)	10/day	40/day	30	300
Coinsurance (60 "lifetime" reserve days)	20/day	80/day	60	300
Coinsurance (21st-100 days - SNF)	5/day	20/day	15	300
Premium-medical insurance (Part B)	3/month	8.70/month	5.70	190

The above figures clearly demonstrate the eroding medical purchasing power of the elderly. Part A deductibles have risen from $40 in 1966 to $160 in 1979, a 300% increase.

Since coinsurance rates are computed from and based on the deductible figure, they have also risen 300% during the same period. As for Part B, the Medical Insurance portion of the program, premium costs are $8.70 per month as of July 1979. This is a 190% increase from the $3.00 figure in 1966.

These statistics must be considered in relation to the cash benefits afforded to senior citizens by the Social Security Program. In 1965 the average cash benefit for retired workers was $84 a month. This figure rose to $318 in July of 1979, a 278% increase.[10]

RISING COST OF MEDICAL CARE

The problems faced by the elderly in paying for their medical care are severely compounded by the fact that the overall cost of health services is rising far faster than inflation in most other portions of the economy. In 1966 the cost of treating an elderly patient was $445. This figure rose to $1738 in 1977, a 300 percent increase.[11] Because 29 percent of the elderly's medical expenses are paid directly by the patient, these increasing costs are exceptionally hard on the elderly.[12] In 1977, the average senior citizen's out-of-pocket medical expense bill was $563, approximately three times as much as the average bill paid by individuals under the age of 65.[13]

One reason the elderly pay more out-of-pocket for their medical care is that fewer physicians are agreeing to accept full payment from Medicare for their services, or "assignment" as it is commonly known. When a physician does not accept assignment, the elderly patient is responsible for the difference between what Medicare will pay and what the doctor charges for a particular service. Today, only 50.5 percent of all physicians accept assignment, a 15 percent decrease since 1969.[14] The decrease in physician participation undoubtedly means more senior citizens are paying a greater portion of their medical expense bill than ever before.

MEDICARE BENEFITS AND LIMITS

As mentioned earlier, Medicare was never designed to meet or to pay for all of the health needs of the elderly. The performance of Medicare, however, has been much less than satisfactory, even for those with knowledgeable, realistic expectations for the program. As also noted in Tables 1 and 2, some of the program's limitations are summarized below.

1. **Cost-Sharing Provisions** - Under Part A, Hospital Insurance, the patient must pay an initial deductible of $160 for each benefit period entailing hospital care. From the 61st to the 90th day, the patient must pay $40 for each day of care. From the 91st day to the 150th day of hospitalization, the patient pays $80 per day.

Under Part B, the Medical Insurance Program, the patient must pay monthly premiums of $8.70. After paying a deductible of the first $60 of "reasonable charges" for covered medical expenses in each calendar year, the patient is also responsible for 20 percent of the charges for any additional services covered by Medicare.

2. **Lifetime Reserve Days** - After the 90th day of hospitalization, patients start using their 60 lifetime reserve days of hospital care. Once these reserve days are expended (they can only be used once), Medicare Part A coverage ends. The patient is then responsible for *all* costs. If poor and unable to pay the patient can become a Medicaid recipient.

3. **Skilled Nursing Home Care** - Medicare, Part A, places severe limitations on nursing home care benefits—in spite of the acute need for this kind of service. The extent of these limitations is best exemplified by the fact that although 23 percent of all medical expenses of the elderly go for nursing care, Medicare paid for about three percent of these expenses in 1977 (Medicaid paid for 42 percent).[15] Approximately one million senior citizens use nursing homes each year at an average annual cost of $13,000.[16]

The Federal Government's "Medicare Handbook" lists the following five eligibility requirements for care in a Medicare certified SNF:

- A person must have been in a hospital for at least three days in a row (not counting the day of discharge) before transferring to a participating SNF.
- The patient must be transferred to a SNF to obtain care for a condition which was treated in the hospital.
- A doctor must certify that the patient needs and actually receives skilled nursing or skilled rehabilitation services on a daily basis.
- A patient must be admitted to a SNF within a short time (14 days) after leaving the hospital.
- The facilities' Utilization Review Committee (URC) or a Professional Standard Review Organization must

approve of the stay.
Since *all five* conditions must be met, access to this kind of necessary care is very difficult. There are also some coinsurance payments required by the elderly who obtain care in a SNF. Medicare does pay the entire cost for the first 20 days. From the 21st through the 100th day, however, the patient must pay $20 per day. After the 100th day, the patient pays *all costs.*

4. **Custodial Nursing Home Care** - Despite the fact that most senior citizens require custodial (not skilled) nursing care, Medicare only pays for care received in a skilled nursing facility.

5. **Psychiatric Inpatient Care** - Part A of Medicare pays for no more than 190 days of psychiatric inpatient care in the course of a person's lifetime.

6. **Home Health Care** - Restrictions on home health services are limited and are very similar to those governing skilled nursing care. Medicare, Part A, pays for up to 100 home health visits in a calendar year. Most of the personal and custodial care services needed by the elderly patient are not covered.

7. **Physician Reimbursement** - As noted, under Part B of the Medicare program, physicians (if they accept assignment) are often reimbursed 80 percent of the "reasonable" charges for services covered by Medicare. Reasonable charge is the *lowest* of either the doctor's charge, the customary charge, or the prevailing charge in the area. If a physician does not accept assignment, and his fee exceeds what Medicare will pay, the patient is responsible for paying the difference.

8. **Services Not Covered** - Many important services, often major expenditure items for the elderly, are not covered at all by Medicare. Some of these include: out-of-hospital drugs, dental care, eye or hearing examinations, eyeglasses, hearing aids and dentures. According to the Social Security Administration (SSA), only 22 percent of older Americans have private health insurance coverage for out-of-hospital prescription drugs; less than three percent have any form of dental coverage.[18]

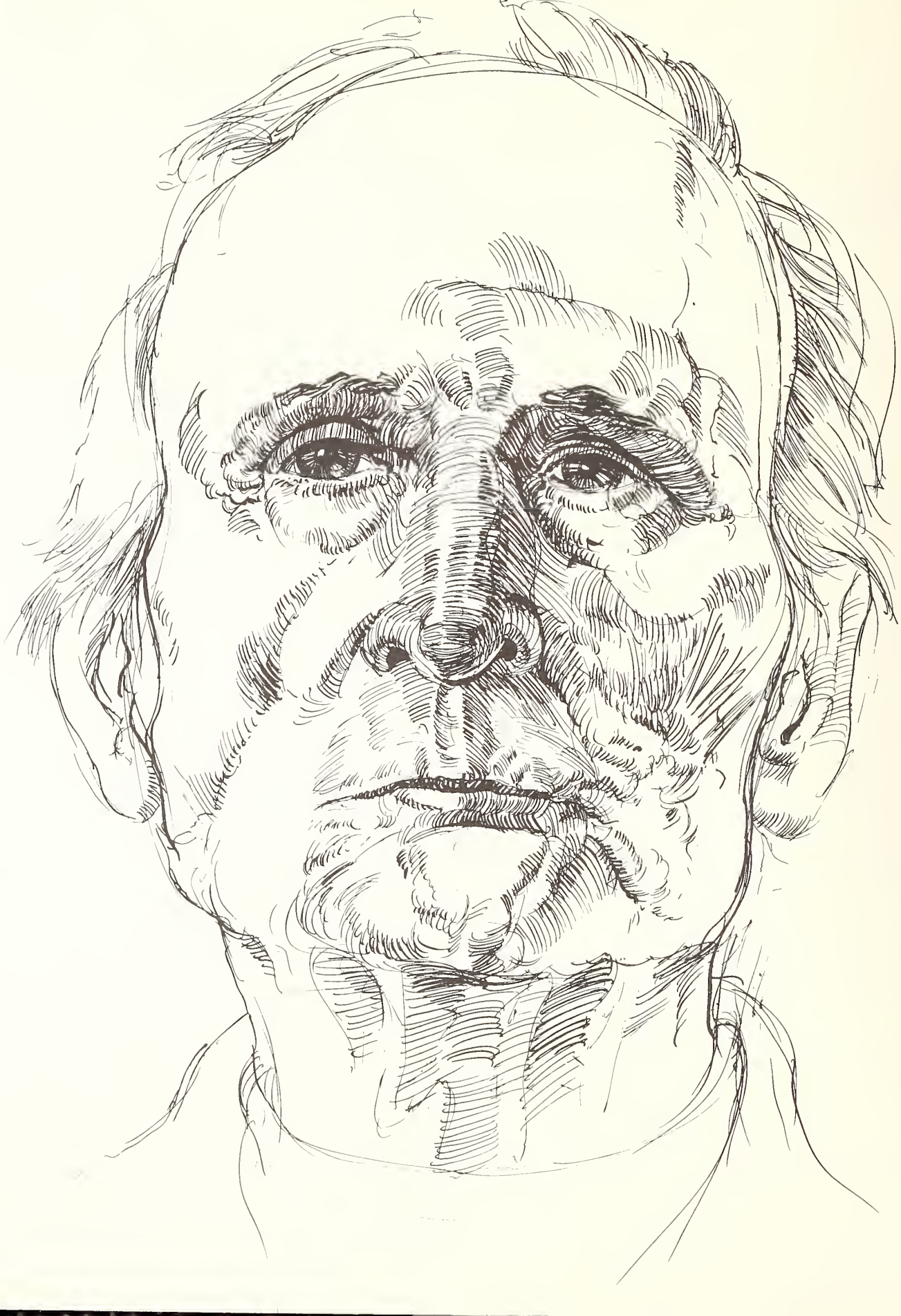
9. **Preventive Care Services** - Medicare does not reimburse for any health maintenance or preventive care services such as routine physical examinations, diagnostic tests and immunizations.

TABLE 2

MEDICARE BENEFITS and LIMITATIONS

KIND OF CARE	MEDICARE PAYS	PATIENT MUST PAY (1979)	COMMENT
Part A - Hospitalization	Days 1-60 Days 60-90 Days 90-150 After 150 Days - No Coverage	Initial Deductible ($160) Daily Deductible ($40) Daily Deductible ($80) For *All* Care	- Adjusted Annually - Adjusted Annually - Adjusted Annually - Reserve Days (60) Usable Only Once - Care Must Be Under Doctor's Orders and Only Be Available in Hospital
Part A - Psychiatric Hospitalization	Days 1-190 After 190 Days - No Coverage	Initial and Daily Deductible For All Care	Only 190 days of care Available in Lifetime
Part A - Nursing Homes Skilled Nursing Care	Days 1-20 Total Days 20-100	Nothing Daily Deductible ($20)	- Must Be In Medicare Certified SNF - All Five Provisions Must Be Met For Reimbursement (Including prior hospitalization)
	After 100 days- No Coverage	For All Care	- No Coverage For Custodial Care - No Coverage For Private Duty Nursing Or First 3 Pints of Blood
Part A - Home Health Care	100 Visits In 12 Month Period - Total Cost Of Care For Part-Time Skilled Nursing, Physical Therapy and Several Other Services	For Most Other Home Health Care	- Patient Must Meet Six Conditions (Including Prior Hospitalization or SNF Care) - Doesn't Cover Full-Time Nursing Care At Home, Drugs, Meals and Homemaker Services - Must Be Confined To Home and Be Under Doctor's Orders
Part B - Home Health Care	100 Visits In A Calendar Year	$60 - (Part B Yearly Deductible) and All Non Covered Services Provided	- Patient Must Meet Four Conditions To Obtain Reimbursement (Including Must Be Confined To Home and Be Under Doctor's Orders) - Does Not Require Prior Hospitalization - Can Provide Coverage *After* 100 Visits Under Part A
Part B - Physicians and Other Medical Services	Cost of Care: Except	Initial Dedictible ($60/yr.) and 20% Of All Charges Above $60 (Determined To Be Reasonable and Covered by Medicare in a Calendar Year)	- Pays For Doctors Services, Outpatient Hospital Care, Outpatient Physical Therapy and Speech Pathology Services, and Other Services - Reasonable Charge Is *Lowest* Of Customary, Prevailing, Or Actual Charge
Outpatient Mental Illness	$250/yr.	All Cost Above $250	
Ambulance Transportation	Most	All Other Costs	- Available Only When Other Forms Of Transport Would Endanger Patient's Health

KIND OF CARE	MEDICARE PAYS	PATIENT PAYS	COMMENT
Drugs	For Drugs Which Must Be Administered	All Other Times	
Immunizations	If Required For Treatment and Ordered By Physician	All Other Times	
Dental Care	Jaw Surgery and Setting Fractures Only	All Other Costs	
Dentures	Nothing	Total Cost	
Hearing and Eye Exams	Nothing	Total Cost	
Eyeglasses and Hearing Aids	Nothing	Total Cost	
Routine Physical Exams	Nothing	Total Cost	
Most Routine Foot Care	Nothing	Total Cost	
Chiropracter's Services	Manual Manipulation of Spine	All Other Costs	
Prosthetic Devices	Most	All Other Costs	
Blood	Most	For First 3 Pints	- Some Coverage Under Both Part A and Part B
Medical Supplies	Dressings, Splints and Casts	All Other Costs	



III. PRIVATE HEALTH INSURANCE

As evidenced by the preceding discussion, the elderly have a legitimate concern regarding Medicare and its ability to adequately address their financial needs during times of illness. Despite the fact that private health insurance pays for a relatively small portion of the elderly's total health bill — five percent — more people over 65 now turn to private health insurance to augment their Medicare benefits than ever before.

Many federal and state officials, although acknowledging the important role of private health insurance in protecting the elderly, question the utility of many insurance policies currently sold to the aged population. They also are concerned that many senior citizens, often misinformed about their insurance needs, sometimes purchase unneeded or excessive amounts of health insurance. For example, Harold Wilde, former Commissioner of Insurance for the state of Wisconsin, noted that "20 percent of the people on Medicaid have been shown to have some form of private health insurance" in Wisconsin.[19] As a result, governmental authorities are attempting to answer some of the following questions: Are the kinds of policies and the scope of coverage being offered to those over 65 adequate and appropriate? Are Medigap policies cost-effective and do they offer an appropriate return on the dollars expended for their purchase? And finally, to what extent are marketing techniques used by insurance companies and their agents deceptive or fraudulent?

TYPES OF POLICIES OFFERED TO THE ELDERLY

The Medicare supplemental or Medigap policies offered by the private health insurance industry are as complex and varied as the benefit structure of the Medicare program itself. Under state law they generally fall into the category of health insurance policies, but also may be known as accident and health or disability policies. The vast array of Medigap policies and related benefit packages does provide the buyer with significant options regarding policy benefits and price. For many senior citizens, however, such variety only adds to the confusion caused by the complicated structure of Medicare.

Private health insurance policies marketed to the elderly generally fall into three categories: the Medicare supplement policy (including major medical policies), the indemnity policy, and the limited or dread disease policies. Some of the characteristics of each type of policy are as follows:

1. **Medicare Supplement Policies** - This kind of policy, generally referred to as "wraparound coverage," is the only health insurance which truly supplements Medicare's benefit structure. Designed to fill the "gaps" not covered by Medicare, these policies usually pay some portion or all of Medicare's deductible and coinsurance requirements and a percentage of actual charges unmet by the federal insurance program. Most private health insurers and the Blue Cross plans offer this kind of policy with an almost infinite range of benefit structures and concommitant costs. None of these policies, however, cover physician charges above the rates allowed by Medicare, or services such as routine physicals and custodial care. Many insurance officials feel one *good* Medicare supplement policy is the best insurance protection for most senior citizens.
2. **Indemnity Policies** - Another common form of insurance purchased by the elderly is the indemnity policy. This kind of coverage usually pays a fixed amount of money for each day of hospitalization. Some policies pay from the very first day of hospitalization, others do not.

Indemnity policies are attractive to the elderly because they pay in addition to other insurance held by the policyholder, providing extra income in times of illness. However, benefits are not structured to reflect the actual charges for an inpatient stay in a hospital. With the average cost of a day of hospital care averaging $181 in 1977[20] the usual indemnity benefit from $20-$50 per day does not provide any real financial protection for the aged patient. Also, considering the fact that in 1976 the average hospital stay for someone over 65 was 11.5 days, the overall payout of an indemnity policy, especially in relationship to the premium paid, is usually quite limited.[21]

3. **Limited Policies** - Another form of indemnity insurance sold to the elderly is the limited or "dread disease" policy. The most prevalent kind of limited policy is cancer insurance. As the second leading cause of death in this country, cancer poses a special concern to senior citizens. It is a protracted and expensive illness. The average cost of treating a cancer (other than skin cancer) patient is around $20,000.[22]

Because most benefits are keyed to hospitalization, limited or dread disease policies do not provide cost effective insurance protection for senior citizens. The average cancer patient stays in the hospital for seven days and is hospitalized only 1.8 times in a two year period.[23] As a result, the rate of return to policyholders is so low that only one of six people who contract cancer ever break even on the money paid in premiums for these policies.[24]

Dread disease policies are currently the subject of a great deal of controversy and concern. In some cases, their fragmented, narrow protection and the low rate of return have made these policies and those companies selling them the target of investigations by regulatory authorities. A few states, including Connecticut and New Jersey, totally prohibit the sale of dread disease policies. Several consumer advocacy groups recommend that senior citizens not purchase limited policies. These groups note that the insurance dollars spent on dread disease policies would provide more financial protection if invested, or if used to purchase a more comprehensive Medicare supplement policy.

MAJOR PROBLEMS AND LIMITATIONS

Serious problems do exist in the private health insurance marketplace in terms of both the benefits provided to elderly policyholders and the techniques used by some companies and agents to sell such policies. These problems are difficult to document, much less resolve on a comprehensive basis. A series of Congressional hearings in 1978 on Medigap issues, and the report issued by the Federal Trade Commission in July, 1978, dealt extensively with problems in the health insurance marketplace. Special attention was given to seemingly widespread agent abuses in the sale of health insurance to the elderly population. This section summarizes some of the most pronounced problems and abuses noted by these investigations.

1. **Lack of Standardization** - One of the basic problems with private health insurance is the lack of policy standardization. Since insurance companies offer an almost unlimited variety of benefit packages, it is virtually impossible for the elderly to select the best, most appropriate kind of coverage.

Some policies provide benefits which are structured to cover only Part A or Part B of Medicare. Still other policies are more comprehensive and extend coverage to both Part A and Part B services or mix payment for services with indemnity benefits. Because many elderly persons do not adequately understand the limitations of Medicare, they are even more confused by the wide assortment of policies designed to supplement Medicare's gaps. It is also difficult to compare the benefits and price of one policy against those offered by other policies.

Many factors, including the size of commissions paid to agents, influence the cost of a policy to a significant degree. Thus, there can be wide variations in the cost of relatively similar policies. Confused shoppers, however, often cannot ferret through the bewildering array of policies and benefits to note an inordinate price differential, or more basically, to determine if they are getting the most insurance for their money. Unless policies are standardized, at least to some degree, there is a reduced incentive for insurance companies to truly compete in the open marketplace.

2. **Duplicate/Excessive Coverage** - Because of the complexity of Medicare and private health insurance, many senior citizens fail to understand their insurance needs or the benefits provided by the policies they purchase. For example, few senior citizens realize that no Medicare supplement policy covers physician's charges above the "reasonable" rate approved by Medicare. Most of the aged also are unaware that their policies do not pay for services such as physical examinations, custodial care and out-of-hospital prescription drugs.

In an effort to obtain "complete coverage," senior citizens have purchased one, two, or *many* health insurance policies. An all too frequent combination of fear, confusion and ignorance have led to some of the following examples of excessive and duplicate coverage.[25]

- A 76-year old Illinois woman was sold some 71 life and hospitalization policies after she was widowed in 1976. Some 42 of the policies are currently in effect (November 1978). It was reported she had to mortgage her farm to keep up with the premiums, which in one year amounted to $15,000.
- An 80-year old Pennsylvania woman spent over $50,000 on 31 policies over a 3-year period. She took out a $3,000 loan from a bank to make insurance payments.
- A Pennsylvania widow, also near 80, was spending $100 of her $109 old age pension on insurance. She said she sold baked goods and dipped into her small savings to survive.
- An 87-year old Wisconsin woman purchased 19 different policies from six agents representing nine companies and costing $4,000. As in these other cases, the policies were

largely worthless because of duplication.

- A Florida couple delayed repairing their refrigerator, television and stove because they were trying to keep up with $2,882 in yearly premiums on 19 separate insurance policies.

While extreme, unfortunately these cases are not unique. Senior citizens often buy too much insurance when one good Medicare supplement is usually all they need. Moreover, because most Medigap policies include a coordination of benefits clause (i.e., only one policy pays when multiple policies offer the same coverage), duplicate insurance is usually worthless.

3. **Policy Clarity** - Most people, young and old, have a difficult time deciphering the complex provisions of an insurance policy. Small print, numerous exclusions, policy riders, and a plethora of medical and legal terminology are but a few of the barriers confronting anyone attempting to evaluate a policy. Often, these problems are exacerbated by failing memories, poor eyesight or other infirmities of old age. Many senior citizens either cannot or do not read their policies carefully and many have a difficult time understanding and remembering specific provisions. As a result, a large number of the over 65 population rely very heavily, sometimes entirely, on what they are told by insurance agents.

4. **Low Loss Ratios** - One measure of the relative value of an insurance policy to the policyholder is the loss ratio (i.e., the percentage of premiums returned to the policyholders in the form of benefits). Although a policy or group of policies should not be judged *solely* on their loss ratios, Medicare supplements are often criticized for not offering a good return of the premium dollar.

Loss ratios of policies vary considerably for group and individual insurance policies. Blue Cross and commercial insurance companies, which sell *only group* Medigap policies, account for about 60 percent of all such policies sold in the United States.[26] The loss ratios for most group insurance sold by these firms are high, averaging around 80 to 90 percent, and offer the best protection for senior Citizens.[27] Most group insurance is marketed through an employer, spreading risk more widely and resulting in less direct expense (i.e., overhead and commissions) to the insurance company. The money saved by selling a policy on a group basis is returned to the policyholder in the form of more benefits and lower premiums.

Policies sold on an individual basis by commercial insurance companies usually offer a much lower return to the policyholder. For instance, the average loss ratio of hospital indemnity, nursing home and low value Medicare supplement insurance is about 40 percent.[28] Many Medigap policies, especially the hospital indemnity and dread disease policies, have exceptionally low ratios—some as low as 22 percent.[29]

Unfortunately, most state insurance departments do not require separate reporting figures for Medicare supplement, indemnity and other limited health insurance policies. This makes a clear assessment of the Medigap problem most difficult. Table 3, which was compiled from a questionnaire developed by the House Select Committee on Aging, demonstrates the wide range of Medicare supplement loss ratios experienced by a number of companies and how they compare with the ratios for all health insurance.[30]

The private health insurance industry counters criticism regarding low loss ratios by saying that Medicare supplement policies are still fairly new business and that loss ratios will increase as more benefits are paid out over time.[31] This argument does not satisfy many critics. They cite the wide range of loss ratio data as the best indicator that low ratios can be avoided. They also point to the very high overhead, attributed in part to excessive commissions paid agents for writing new individual policies, experienced by some companies. Companies generally pay commissions ranging from 40-75 percent (and higher) of the premiums for *new* individual insurance policies. The elderly end up paying for this high commission and get little in return in the way of benefits.

5. **Clauses for Preexisting Conditions** - Many health policies contain a clause which limits or excludes payment for conditions existing at the time of purchase. Most mail order insurance and insurance purchased on an individual basis use the preexisting or "pre-x clause." These Medigap policies usually do not cover any preexisting condition for six months to a year after the policy is in force.

Table 3
Returns on All Insurance as Compared with Medicare Supplement Policies Selected Companies 1977

COMPANY	PERCENT RETURN ON ALL INSURANCE*	PERCENT RETURN ON MEDICARE SUPPLEMENTS
Mutual Protective Insurance	35	22
Medico Life	28	25
Mony	66	28
New York Life	75	28.7
American United Life	83	28.9
National Casualty Company	59	30
American Progressive	47	33
National Security Insurance	21	35
Reliable	37	36
Constitution Life	78	37
Old American	45	38
Pioneer Life of Illinois	40	39
Liberty National Life	46	40
Pacific Mutual	85	40
Businessmen's Insurance	99	43
American Exchange Life	43	44
Commercial State Life	51	17
Union Bankers	53	48
Country Life	71	49
Aid to Lutherans	44	50
All American Casualty	87	52
CNA	82	55.4
Bankers Life and Casualty	67	57
Guarantee Reserve Life	62	57
American National	81	57.5
American Variable Annuity	85	63
Chesapeake Life	90	65
Guardian Life Insurance	82	66
Mutual Benefit Life	72	70
Banker's (Iowa)	82	75
Home Life	76	77
Nationwide	79	78
Durham Life	67	79
Life of Virginia	78	82
Metropolitan	75	83
National Life and Accident	59	85
Provident Mutual	79	86
Blue Cross/Blue Shield	—	91

* Figures in this column estimated.

Because many elderly have long-term illnesses, the pre-x clause can limit, if not void, much of their insurance protection. Also, through policy riders and strict interpretation of the provisions, some companies avoid paying apparently valid claims—even after the waiting period has elapsed. The denial of claims due to pre-x clauses is commonly referred to as "post-claims underwriting" and is often a major problem for senior citizens.

One other important problem also arises regarding the application of preexisting clauses. Some elderly patients buy "new" or "improved" policies and discontinue their current coverage, often on an annual or more frequent basis. Commonly referred to as "rolling over" or "twisting," this practice—often done with the knowledge of the agent —leaves many older people completely uninsured because one preexisting clause or the other is always in force. High commissions paid for writing "new" insurance provides a great incentive for an unscrupulous agent to indulge in this kind of activity.

6. **Claims Handling** - A lack of understanding about what a policy covers frequently results in a claims dispute between the insurance company and the policyholder. According to a survey of the 50 states by the House Select Committee on Aging in 1978, the three most prevalent types of complaints filed with state insurance departments are: 1) companies refusing to pay on the grounds of preexisting conditions; 2) companies not paying refunds of the premium; and 3) complaint disputes regarding the amount a company paid on a claim.[32] Complaints to state insurance departments are imprecise but good indicators of a company's marketing practices and how well policyholders understood a policy's benefits package.

As part of their study, the Select Committee on Aging attempted to quantify the states' complaint experience and develop a method to evaluate insurance company performance. The states were asked to rank the top 50 companies selling more than $50,000 in health insurance along with the number of complaints received about each company. States were also asked to rank the 50 companies by complaints per $100,000 in premium income and to compare this figure with the states' average. Although only three (Wisconsin, West Virginia and Missouri) were "able and willing to provide the requested information in full," preliminary information suggested that the average number of complaints per $100,000 in premiums was close to .40 per $100,000. The average rate for Wisconsin was .21 complaints, .32 complaints for Missouri and .94 complaints per $100,000 of premiums in West Virginia.[33] This kind of detailed analysis of company performance could be a valuable guide for the elderly when shopping for health insurance.

Many insurance company and agent abuses go undetected or prosecuted because many senior citizens do not know that they can file a complaint with the insurance commissioner. Also, older people often hate to admit there is a problem or that they have been "taken." Monitoring all of the elderly's complaints, however, including those made directly to the insurance companies, is extremely difficult because many states do not require insurance companies to keep meaningful, comprehensive records of complaints.

7. **Mail Order Insurance** - The elderly population purchases a significant number of Medigap policies through the mail. National senior citizen organizations such as the American Association of Retired Persons (AARP) and an array of large and small insurance companies use the mail to market health insurance. Many Medigap policies sold by mail are not true Medicare supplements—they are limited policies offering indemnity benefits. Companies selling mail order insurance are often criticized for using deceptive marketing techniques and for playing on the fears of those over 65.

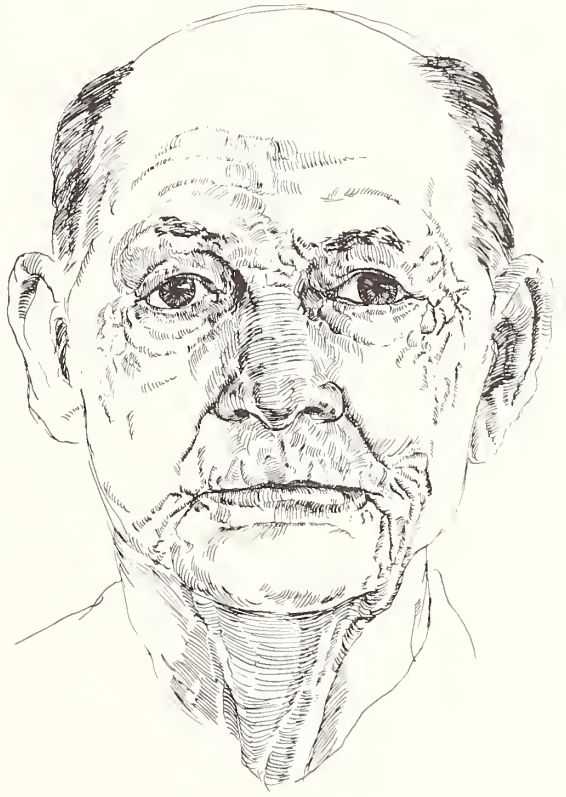
Mail order insurance poses a difficult problem for those attempting to monitor and regulate the insurance industry. At the moment, neither federal nor state law adequately regulates this kind of insurance.

Because of the "gaps" in regulatory authority, a mail order insurance company licensed in one state can market its insurance to residents in another state, in some cases effectively circumventing state law. This is especially true for group insurance offered through the mail. The federal government does not assume responsibility for mail order abuses because of the limitations imposed by the McCarran-Ferguson Act. State laws are sometimes ineffective for a number of reasons, one being that state laws generally do not apply to companies not licensed to do business in that state. Another problem is the nature of group insurance itself. Because group insurance is designed to cover large numbers of people in multi-state jurisdictions (i.e., a large company with operations in many states), it is virtually impossible to mandate modifications in a group policy that conform to each state's insurance codes.

Probably the most difficult mail order problem for states, however, is the use of insurance "trusts." Some insurance companies set up a trust in the states where they are licensed for the sole purpose of selling group mail order insurance in other states. When a policy is purchased, the insurance company files the certificate of insurance with the trust—not in the state where the policyholder resides.

Many states, including Wisconsin and New York, are attempting to modify or test their laws to enhance the power of the state insurance department to regulate this kind of activity. An appeal by Albert E. Lewis, Commissioner of the New York Department of Insurance, before the House of Representatives in November of 1978, exemplified the frustration of many officials at the state level regarding this matter.

> "I can't stop this kind of insurance I don't think. We are going to try to stop it. It is mail order. If you really want to do something gentlemen, stop the mail order sale in my state of policies that my state bans."[34]



8. **Marketing Abuses by Insurance Agents**

Congressional investigators, and other officials monitoring the health insurance industry, have found that deception, fraud and high pressure sales techniques, are all too common in the sale of Medicare supplements to the elderly.

In one part of the inquiry by the Select Committee on Aging, investigators found only eight of 50 agents were "scrupulously honest" when offering advice about insurance needs and adequacy of coverage.[35] Investigators also found, however, that strict enforcement of insurance regulations can, in some cases, virtually eliminate unethical practice by agents.[36] In general, although the extent of marketing abuses is unknown, the Congressional staff found abuses to be widespread and occurring on a nationwide basis.

In an effort to document the extent of certain marketing problems, the House Committee staff compiled a list of some of the more common agent abuses and sent a questionnaire to the state insurance commissioners. Many indicated they had seen instances of all 22 listed abuses in their respective states. Special counsel for the Select Committee on Aging, Val J. Halamandaris, noting the results of the survey before the Aging Committee on November 18, 1978, described the most common abuses, along with the number of states (noted in parentheses) which said the abuse was a common problem.[37]

- Wolf in sheeps clothing (34) - The agent fails on initial contacts with clients to disclose that he represents a for-profit insurance company. He may say he is from Medicare and wants to help seniors with any problems they may have.
- The Government Look (38) - Agents and/or companies use advertising materials that tend to associate them with the federal Medicare or social security program. Using the above, the agent implies that he is from a Government agency without saying so outright.
- New is better ("Twisting" or "existing policies are gar bage") (44) - The agent encourages the client to cancel perfectly good existing policies to sell a new policy which results in additional commission fees.
- Overselling (44) - The agent sells the client more coverage than they need or can pay for or both - also known as "stacking." If you have two or more policies offering the same benefit, you only get paid once.
- Clean Sheeting (or "failure to report material condition") (41) - The agent fails to report pre-existing health conditions of clients to company, ultimately leading to a pre-existing condition disqualification of coverage when claims are filed.
- Forgery (30) - The agent either signs someone's name to the insurance forms or encourages the elderly client to illegally sign name of insured or of a loved one.
- Scare Tactics (38) - The agent employs scare language in closing the sale like "buy now because you may not be able to be insured later," etc.
- Make the check out to me (49) - The agent asks that the client make the check out to him. The agent then cashes the check, and does not report the transaction to the insurance company. No policy issued.
- The switch (25) - The agent sells the client one policy but then switches and provides another for signature at time of closing.
- Pie in the sky (or "fine print") (39) - The agent misrepresents policy content with words like "no waiting periods," "this policy will pay for everything," etc.
- I work with X (28) - The licensed salesman allows an unlicensed person to front for him.
- The fence post policies (18) - The agent completes applications in the name of relatives or others, unknown to the victims. This is done to bypass underwriting rules when it is known the victims already have the maximum coverage in effect with a company.
- Group policy (21) - The agent represents the policy as a group policy with the implication that premiums are less when in fact there is no group and the policy is the same in coverage and premium as a regular policy.

Several state commissioners cited other kinds of abuses which they had uncovered. These include:

- The merry-go-round - An agent who is fired from one company, or leaves voluntarily, visits all the clients he previously sold insurance. He may say something like "my company bought your old company" or "I'm with a better company now" as a pretext to replacing all of company No. 1's policies with those of company No. 2.
- Teamwork - Two or three agents visit you. The high pressure team may ask how much is in your bank account to "help them" determine if you can "afford" the insurance.

The role of insurance companies in promoting or sanctioning deceptive or fraudulent behavior by their agents is difficult to ascertain. Most insurance companies do not condone such practices. It is evident, however, that some companies do instruct their agents in "hard sell' and "pressure" tactics and specifically target sales to exploit the fears and weaknesses of the elderly. In some cases, "training sessions" attended by Congressional investigators entailed little more than learning how to generate leads and get in the door to talk to senior citizens. These investigators found two general characteristics of companies which accounted for the greatest number of marketing abuses:

- Companies specializing in the sale of individual Medicare supplemental health insurance policies; and
- Companies promoting policies of limited economic value.

The larger, more well-known and established companies which sell Medicare supplement policies were the

least likely to promote or to tolerate marketing abuses by their agents.

Marketing abuses by agents occur for many reasons. Perhaps the most important is the manner in which agents are paid—on a straight commission basis. Insurance companies often pay the agent 40-75 percent of the premium for writing new business, but only 5-10 percent for renewals. This acts as a tremendous incentive for agents to sell as much new insurance as possible. Some companies also use financial "pressure" to induce their agents to sell more insurance, or to keep them from quitting. For example, Congressional investigators uncovered several instances where the company promoted sales by keeping the agents in debt. This was accomplished by billing the salesmen "enormous sums" for commissions already paid on policies which had subsequently been cancelled. Other reasons insurance companies experience problems with agents include: inadequate screening of agents before they are hired; inadequate internal control mechanisms to monitor policy sales, complaints, and agent practices; and, no ongoing method of maintaining direct contact with the policyholders.

States are also responsible for some of the problems in the health insurance marketplace. Inadequate laws, regulations, and resources (i.e., money and personnel) keep many states from aggressively disciplining companies and agents which engage in fraudulent practices. According to Val Halamandaris, "Only 11 states have disciplined a *company* in the last three years." [38]

IV. THE STATES AND PRIVATE HEALTH INSURANCE

All states have statutes that regulate many aspects of the private insurance industry. States can revoke licenses, impose fines and penalties and take other kinds of remedial action with regard to the sale of most kinds of insurance. In addition, states have specific statutes that apply to the advertising of health insurance and, in some cases, Medicare supplements.

The National Association of Insurance Commissioners (NAIC), a voluntary association of the chief insurance regulatory officials of the states, plays an important role in developing and revising state insurance statutes and regulations. As part of its activities the NAIC develops "model" statutes and regulations that address a wide spectrum of insurance company operations at the state level. State legislators and regulatory officials often refer to these models as a guide when they develop or amend insurance codes. Many states, however, have not adopted significant portions of these laws and others do not have adequate enforcement mechanisms.

The NAIC has promulgated generic model regulations about the sale of health insurance that also affect health insurance for the elderly.[39] These include:

1. **Unfair Trade Practices Act** - This legislation specifies what kind of fair treatment should be offered to policyholders and details what constitutes unfair claims settlement practices. It also authorizes the establishment of regulatory procedures to determine deceptive or fraudulent practice and certain procedures to enforce these regulations once in place. Under this act states have the authority to impose fines, issue cease and desist orders, and revoke licenses due to improper conduct.

2. **Advertising** - These rules, which recognize the need for better, more comprehensive consumer information, attempt to improve insurance company disclosure requirements. They were promulgated because of the many problems which resulted from the use of mass marketing techniques. This model regulation requires (among other things) the disclosure of certain information and prohibits the use of selected words, phrases and illustrations likely to mislead the consumer.

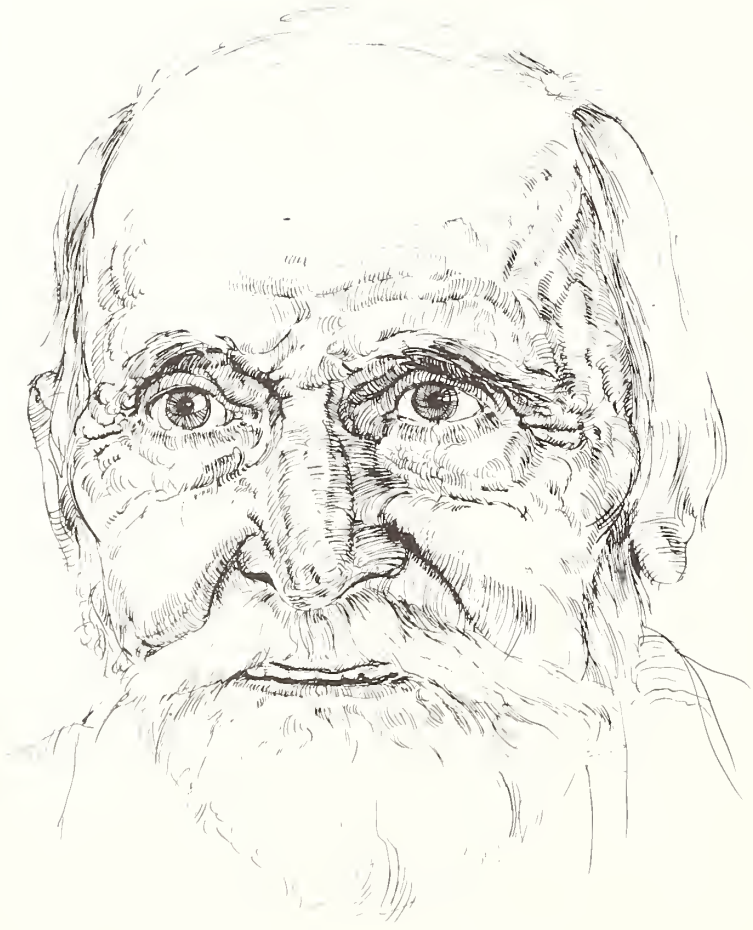
3. **Policyholder Complaints** - NAIC has been actively involved in making policyholder complaint handling more efficient. For example, under the model Unfair Trade Practice Act, NAIC developed a regulation that required insurers to maintain files of policyholder complaints. In another action, it also developed a uniform complaint handling system. This system, when adopted, standardizes the claims handling procedures used by states so that data can be reviewed and compared for regulatory and policymaking purposes.

4. **Premium Rate Controls** - Although all states require insurers to file actual loss experience on policies, health insurance rates—except for those used by the tax-exempt Blue Cross-Blue Shield plans—are not directly regulated by the states. Realizing there should be a "reasonable" relationship between premiums and benefits, NAIC model regulations have been developed which establish loss ratio benchmarks. These benchmarks are used by states in reviewing policy loss experience.

5. **Minimum Standard Requirements** - Since 1973, the NAIC has been working on regulations to implement the Model Individual Accident and Sickness Minimum Standards Act. This model act and regulations establish a framework to: 1) Enable the standardization of the definition of policy terms; 2) Compel policies to meet minimum standards for the category into which they fall; 3) Compel disclosure to the consumer to better enable him to know what he is purchasing.[40] As will be discussed in the next chapter, the NAIC's recently adopted (June, 1979) amendments to the Minimum Standards Act specifically address the sale of Medicare supplements.

6. **Policy Readability** - Because policies usually are difficult to read and understand, the NAIC has developed the model Life and Health Insurance Policy Language Simplification Act in 1978. This model legislation establishes basic standards for drafting a policy. Among its provisions, the act requires that policies achieve a minimum test readability score and sets standards for the size of type face.

In spite of the availability of these model acts and the broad statutory authority currently held by some states to



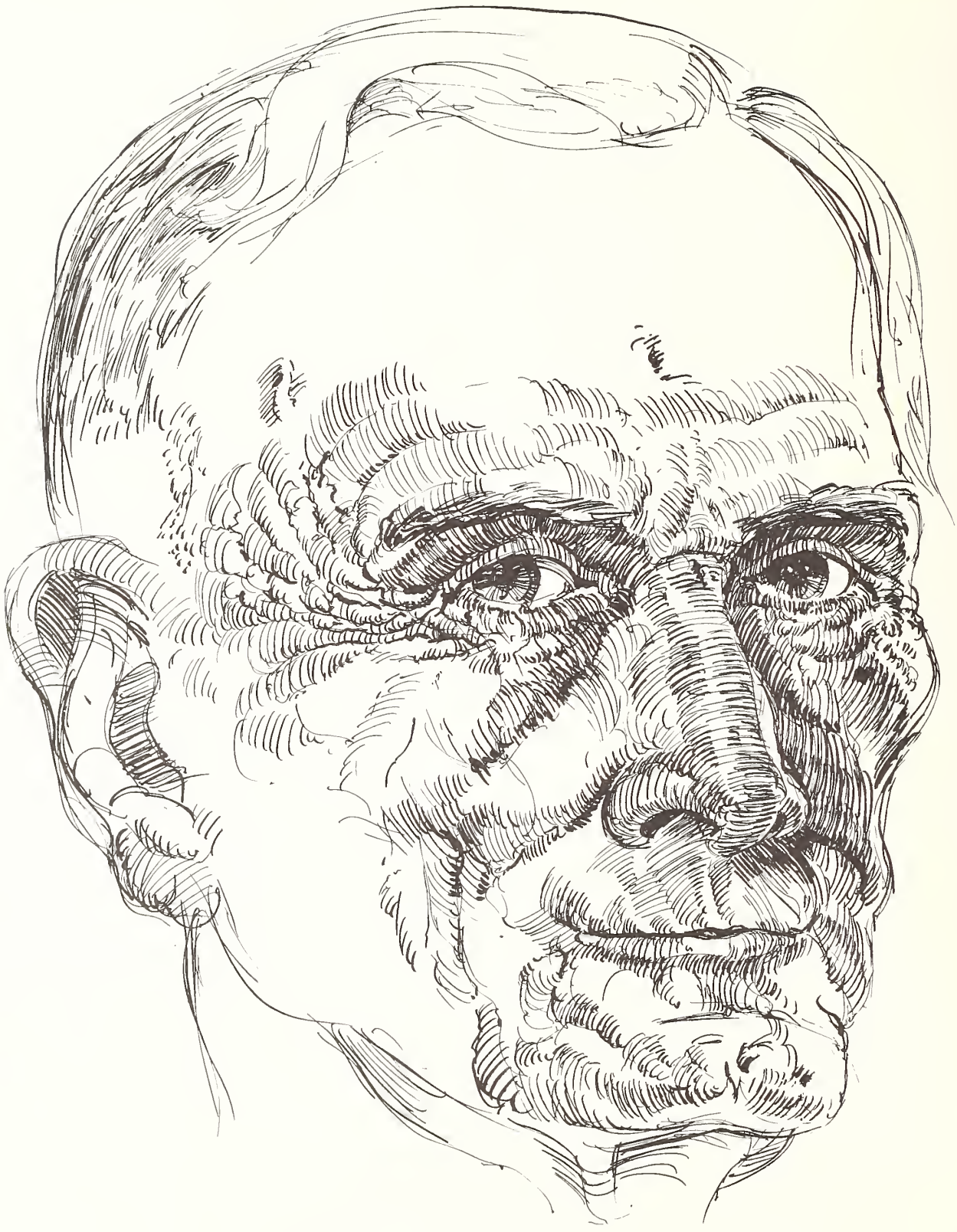
regulate the insurance industry, Congressional investigators found that states are *not* doing an adequate job of regulation. As the basis for this determination they cited the following "gaps" in state regulatory authority in their November 1978 report.[41]

- No state had the authority to regulate health insurance rates (except Blue Cross/Blue Shield).
- Only four states said they could limit the amount of commissions paid to agents.
- Only eight states had mandatory minimum loss ratios.
- Only fifteen states had regulations concerning readability.
- Only seven required the use of approved graphics preceeding any sale.
- Only seventeen had regulation with respect to preexisting conditions.
- Only twenty-five states regulated the size of print of insurance policies.
- Only six states had specific Medicare supplement laws.

As a result of these and other significant findings, the Congressional report indicated that not enough states had acted aggressively to implement needed regulatory mechanisms or to enforce the existing laws and statutes. In fact, the primary conclusion of the report was "that enacted regulations have not been enforced and that most states are not doing an adequate job protecting senior citizens against those unscrupulous companies and agents which would seek them to take advantage of them . . . Enforcement efforts at the state level must be greatly strengthened . . ."[42]

The need for deliberation and resolution of the Medigap problem, as well as effective action at the state level, is summarized in a statement by Senator (and former governor and state legislator) Lawton Chiles to Joseph C. Mike of the NAIC.

> "I think those of us who want to see the States continue to regulate insurance have to be for the action that you are talking about . . . It has always been in an area like this where states often fail in their responsibility, that someone decides, well that is something the Federal Government has got to get into. I just hope that that message will go to all of the insurance commissioners in all of the states."[43]



V. STATE REGULATION OF MEDICARE SUPPLEMENTS

States, both individually and collectively through the NAIC, are beginning to take significant steps to resolve the abuses which occur in the sale of private health insurance to the elderly. The IHPP surveyed state insurance officials in 42 states for this report and found that at least 18 states have statutes or regulations in force which specifically address the sale of Medicare supplements. Several states (e.g., Connecticut, Massachusetts, Michigan, New Jersey, and Vermont) have drafted new or revised regulations that will strengthen their control over Medigap problems. These are expected to be adopted in the next legislative session or in the near future. As noted earlier, most of the remaining states have regulations in place, through their general Accident and Health insurance statutes, which encompass the sale of Medicare supplements.

NAIC's Model Regulation

Many states, although acutely aware of the inadequacies of current insurance statutes and rules, had been waiting for the NAIC to adopt its model regulations governing Medicare supplements—which are amendments to the more generic Individual Accident and Sickness Insurance Minimum Standards Act. Such regulations were adopted in June of 1979 as the result of nearly a year of study by the NAIC, a special task force, and an advisory panel working under the auspices of the NAIC. Specific provisions of the model regulations include:[44]

1. Policy restrictions no more restrictive than those used in the Medicare program,
2. Prohibition of specifically defined pre-exisiting condition limitations in Medicare supplement policies,
3. Prohibition of pre-existing condition limitations longer than six (6) months for conditions for which medical advice was given within six (6) months before the effective date of coverage,
4. A recommended 60 percent loss ratio benchmark, to prevent excessive rates,
5. Automatic coordination with Medicare deductible and copayment percentage factors,
6. Prohibition of use of the words "Medicare Supplement," "Medigap" or words of similar import unless policies meet the minimum standards for such policies,
7. Minimum benefits standards for Medicare supplement policies filling out coverage of all eligible expenses for the 61st through the 90th day under Part A of Medicare; coverage of the daily hospital charges incurred during use of the Part A lifetime reserve; after exhaustion of the lifetime reserve, coverage of 90 percent of all Medicare Part A eligible expenses for an additional 365 days; and coverage of the 20 percent of Medicare eligible expenses under Part B subject to a private policy deductible and maximum benefit of a least specified amount.
8. Full and fair disclosure of benefits, exclusions, and limitations in a specified outline of coverage form,
9. Delivery of a uniform buyers' guide; and
10. A 30 day "free look" provision.

As part of their study, the NAIC, the Health Care Finance Administration (HCFA) and other individuals joined to develop a *Guide to Health Insurance for People with Medicare*. According to Edward J. Birrane, Insurance Commissioner for the State of Maryland, in his testimony before the House Interstate and Foreign Commerce Committee on June 13, 1979, HCFA "is prepared to print millions of copies of this brochure for use by HCFA and the states and will advise all Social Security recipients of its availability."[45] The consumer information booklet should prove most helpful in informing the elderly about the limitations of Medicare and how to go about shopping for private health insurance.

To illustrate the potential impact of the model regulations, at least 14 states reported to the IHPP that *significant* legislative or regulatory activities will result from the NAIC rules in the near future or in the next session of the legislature. Another 10 states anticipate more limited adjustments to their insurance codes. Most of these states, however, (73%) see no need for specific Medicare supplement legislation. Instead, they plan to strengthen their existing insurance regulations.

A LOOK AT STATE LAWS/REGULATIONS

Results of the IHPP survey indicate that, as of September, 1979, only a few states have taken truly comprehensive action aimed at alleviating Medigap abuses. Most other states have taken a more limited approach, usually implementing regulations establishing some minimum standards, such as loss ratios, or strengthening their disclosure requirements. These state actions vary considerably, both in approach and in scope. Even those states with specific Medicare supplement laws and regulations in place, however, are continuing to experience problems.

Some of the most important areas for strengthening state insurance codes in relation to the Medigap problem include provisions governing minimum standards and benefit levels, advertising, and disclosure. CALIFORNIA and WISCONSIN have led the way in instituting some of these important reforms. Both states have extensive minimum standards and disclosure requirements and have developed methods of categorizing Medicare supplement policies. Many states are setting loss ratios for Medicare supplements, some higher than the NAIC recommended "benchmark." CONNECTICUT (65% individual; 70% group) and MICHIGAN (65%) are two states with exceptionally strong loss ratio requirements. At least eight states have new laws or regulations taking effect in 1979. The comprehensive nature of proposed regulations in MASSACHUSETTS, CONNECTICUT, NEW JERSEY, and VERMONT indicates more states are now moving to take truly meaningful action to control the Medigap insurance marketplace.

The following section briefly summarizes selected actions taken to regulate the sale of private health insurance sold to the elderly. It is designed to provide basic information about most current state activities and to generate ideas for those officials wanting to initiate legislative or regulatory reforms in the near future. Other states not included in this list do have general health insurance regulations (e.g., New Hampshire, Texas) which affect the sale of Medicare supplements. Table 4 at the end of this report is a comprehensive summary of specific state actions taken in 18 states to resolve the Medigap problem.

CALIFORNIA

The state of California has assumed a prominent role in devising and implementing comprehensive, innovative policies to address Medicare supplement problems. It has promulgated extensive regulations governing the form, content, and marketing of all kinds of private health insurance to the elderly.

California regulations establish separate minimum standards for Medicare supplements, specified disease, and hospital indemnity policies. Some key minimum standards for each kind of policy are as follows:

Medicare Supplement

- All Medicare supplement policies must fill some of the gaps in both Part A and Part B of Medicare.
- Coinsurance benefits for Part A are required for the 61st - 90th day and for the lifetime reserve days.
- Coinsurance benefits are required for Part B of at least $1,000 per calendar year, whether in or out of a hospital.
- The pre-x clause is limited to six months after the effective date of the policy, or for treatment previously recommended by a physician, to six months before the effective date of the policy.
- The minimum "benchmark" loss ratio for Medicare supplements is 55%.

Hospital Indemnity

- The daily hospital benefit must be at least $15 for no less than 60 days.
- Policies must adhere to strict elimination period, waiting period and pre-x condition provisions.
- Policies may not be labeled as a Medicare supplement policy.

Dread Disease

- A policy's maximum limit must be at least $10,000, or
- A *series* of minimum benefits such as $50 a day for the first 12 days of hospitalization with no elimination periods, deductibles or coinsurance factors, and
- $30 per day for each day of continuous hospitalization.

California is unique in its approach to categorizing Medicare supplements. It has established three classes of Medicare supplements: in-hospital expenses only; in-and-out-of hospital expenses; and catastrophic Medicare supplement coverage. Although no company is required to offer any Medicare supplement, if they do market such policies

they must meet state minimum standards. For instance, a company does not have to offer a catastrophic Medicare supplement, but if it does, the policy must pay for all expenses on a "blanket basis" for conditions covered in whole or in part by Medicare. Catastrophic policies must provide a maximum lifetime benefit of at least $25,000 and have a deductible of not more than $1,000. The insurance company administers these policies like a major medical plan and uses its own UCR (usual, customary and reasonable) data to determine changes.

California requires the use of a separate disclosure form for each of the three categories of Medicare supplements. It also requires special disclosure forms for hospital indemnity and dread disease policies. The disclosure forms briefly describe the type of policy, outline the specific benefits provided or not included, explain exceptions and limitations, and review both the conditions of renewability and the premium charges. Forms must give the name, address and telephone number of a representative of the insurer. The specified number must be toll-free if this representative is out-of-state. Insurers must also set up affirmative procedures to insure the proper use of disclosure forms. California's regulations apply to all individual health insurance policies sold to the elderly, but not to out-of-state mail order insurers.

COLORADO

With the implementation of Regulation 76-6, effective July 1, 1977, Colorado strengthened its disclosure requirements regarding the sale of Medicare supplements and hospital indemnity policies. The regulation does not mention dread disease policies. It applies only to individual policies, not to group plans or to out-of-state direct response insurers.

All application forms for insurance are required to indicate whether the sale of any new insurance would replace or add to existing coverage. If any replacement or additional insurance would be provided, a notice is furnished to the applicant warning about the dangers of cancelling the coverage they now have in force and informing them about overlapping or duplicative coverage. An agent making such a sale must provide the disclosure notice to the applicant at the time of application. A direct response insurer must furnish the notice *before* the policy is issued. In both cases, a copy of the notice is left with the policyholder and a signed copy is retained by the insurer for a period of two years.

Although the disclosure form does include a provision requiring some comparison of Medicare and policy benefits, the regulation is very general in its instructions and leaves much to the discretion of the agent or company making the sale.

CONNECTICUT

The State of Connecticut has enacted a number of laws and has drafted regulations which specifically address the sale of Medicare supplements and other forms of health insurance sold to the elderly. Under a 1975 law, P.A. 75-616:

- Specified disease policies, riders and benefits issued on an individual or group basis were banned in Connecticut.
- The insurance commissioner was authorized to establish minimum standards for all categories of health insurance policies.
- Basic provisions requiring the use of an "outline of coverage"—a disclosure requirement—were set in place. The outline accompanies the policy or is delivered to the applicant at the time of application.
- If a carrier does not adequately document a person's health history, the regulations specify that the policy "shall cover loss developing after twelve months from any pre-existing condition not specifically excluded from coverage by the terms of the policy."

A regulation to implement the disclosure requirement section of the law has been drafted, but has not yet been adopted. Among its provisions, the proposed regulation provides for a number of important disclosure requirements including:

- On the first page of the policy, each policy must include a renewal, continuation or non-renewal provision.
- Most riders or endorsements added to a policy after the date of issue which reduce or eliminate benefits or coverage of the policy require the signed acceptance of the policyholder. This also applies to increases in benefits and concommitant premiums.
- Separate, additional premiums for benefits provided in riders or endorsements must be identified in the policy.
- Any limitations on pre-existing conditions must appear in a clearly labeled, separate paragraph in the policy.

• The right to return the policy within 10 days must be clearly displayed on the first page of the policy.

The Medicare supplement disclosure form lists several suggestions regarding the purchase of Medicare supplements, including a warning to Medicaid eligibles not to buy a Medicare supplement. Also, each company selling a Medicare supplement must prominently display its name, address, telephone number and toll free "800" number on the front of the outline of coverage. The outline provides comparisons of what Medicare pays and what the policy pays for Medicare Part A, care in a skilled nursing facility, and Part B. It also provides a separate section for "Miscellaneous Services or Benefits."

When the insurance to be issued is intended to replace or duplicate other insurance already in force, proposed disclosure requirements (similar to Colorado's) also call for the insurers to provide a notice to the applicant. Separate notices have been drafted—one in case of replacement, another in case of duplication. Both must be delivered to the applicant *prior to* the delivery of a policy. The Connecticut rule also requires that the notice must be signed and retained by the insured and the insurer.

Finally, the Connecticut legislature passed a bill, P.A. No. 79-289, in the 1979 legislative session which establishes loss ratios for insurance policies supplementing Part A of Medicare. The law applies to "any individual or group accident and sickness policy or certificate or individual subscriber contract delivered or issued for delivery to any resident of the state who is eligible for Medicare." Individual Medicare supplements must have an anticipated loss ratio of not less than 65 percent. Group policies have a minimum loss ratio of at least 70 percent. The law becomes effective on October 1, 1979.

ILLINOIS

The state legislature passed Public Act 80-435, effective October 1, 1977, which established minimum standards for Medicare supplements. The law applies to both individual and group policies issued in that state, but does not cover mail order insurers not licensed to do business in Illinois.

The statute requires that all Medicare supplements must include at a minimum, the following benefits:

• The initial inpatient deductible as determined under Medicare;

• Daily coverage for each day from the 61st-90th day of hospital care;

• The daily coinsurance payment rate under Medicare for the 60 lifetime reserve days;

• The Part A copayment for the 21st-100th days of SNF care;

• For physician care while an inpatient, at least 20 percent of the reasonable charges allowed under Part B with a minimum deductible of $200 per benefit period and a maximum benefit of at least $1000 per benefit period.

The Illinois law does contain some disclosure provisions. Basically, they prohibit certain representations by advertisements or agents in the sale of Medicare supplements. However, neither the law nor current regulations mandate the use of a special disclosure form.

Amendments to Sections 363 and 363a of the Illinois Insurance Code have been drafted by the Department of Insurance, but probably will not be acted upon by the legislature until next year. The proposed changes, which focus primarily on disclosure requirements, are quite extensive. They include:

• Mandatory agent practices, including clear identification procedures and the use of a policy check list to determine whether a policy is suitable and nonduplicative. The check list must be completed (in duplicate) by the purchaser at the time of sale, must be signed, and copies must be retained by the policyholder and the company. Copies of the check list must be on file at a company's regional or other administrative offices. No Medicare supplement policy can be issued (or premiums paid must be returned) if a policy is found to be duplicative.

• A provision that the disclosure form must indicate whether the policy does or does not meet the minimum

standards for Medicare supplements in Illinois.

- An Outline of Coverage must be issued with every policy or certificate. It reviews what the policy does and does not pay, lists exceptions, reductions, and limitations, and discusses renewability and premium information.
- Penalties for agents and companies are established, for each violation of Section 363, of not less than $100 and not more than $1,000 for each offense.

MASSACHUSETTS

The Massachusetts insurance department held hearings on Medicare supplements in the Summer of 1979 and subsequently adopted important regulations amending the state's insurance code. These amendments, Rules and Regulations Governing Accident and Sickness Insurance, added Chapter 47.00 to Section 211 of the Code of Massachusetts Regulations. Filed with the Commissioner of Insurance in late September, 1979, the regulations are significant changes in Massachusetts' regulatory activities as they pertain to all types of private health insurance sold to the elderly. Because they offer some new approaches to several aspects of Medigap regulation, they warrant close inspection by other states.

The new regulations are designed to address a wide range of Medigap problems and issues including: minimum standards; policy simplification and clarity; full disclosure of policy contents; the use of loss ratios; and deceptive sales practices. They apply to all individual accident and sickness insurance policies, and to non-group subscriber contracts of non-profit hospital, medical, and dental service corporations filed with the division of insurance, delivered, or issued for delivery after the effective date of the regulation, except for group conversion policies or contracts.

The following is a brief summary of some of the regulation's major provisions:

General Minimum Standards/Definitions

- The text of all policies, riders, and endorsements should have a Flesch test readability score of 50 or more.
- Limitations on benefits (i.e., exclusions, waiting periods) should be clearly labeled in a separate section of a policy.
- A pre-existing condition is defined as *either* a medical condition which caused a person to receive medical advice or treatment during the 12 month period prior to the effective date of coverage *or* a medical condition during the same 12 month period causing symptoms which would have led an ordinary prudent person to seek medical advice or treatment for that condition.

Specified Disease Coverage

The new Massachusetts regulations effectively ban the sale of dread disease policies. Dread disease policies can still be sold in the state, but they cannot limit their coverage to any single disease such as cancer.

- Each specified disease policy must have a maximum benefit of *no less* than $10,000 and must provide benefits for at least *twelve specific conditions* cited in the regulation. These conditions include "cancer in any of its manifestations." Specified disease coverage must be guaranteed renewable until age 65 and may *not* be sold to anyone over the age of 65. Policy benefits can be no less than $150 for semi-private accomodations or charges, whichever is the lower, for at least 60 days of continuous hospital confinement. Other benefits must provide a maximum of at least 10% of the total aggregate maximum benefits.

Medicare Supplement Insurance

- This insurance may not be sold to anyone not covered by Medicare Part A and B.
- Three categories of Medicare supplements are established, each of which is mandatory "as to standards and benefits and may not be modified in any manner." The three plans are very similar regarding most basic inpatient and outpatient services; however, the two lower option plans have less coverage for certain services, for instance, inpatient private nurses and drugs used outside a hospital which require a prescription.
- Each policy must include a provision that benefits "will be automatically changed to match any changes in Medicare cost sharing."

Disclosure Requirements

- Each category of insurance covered by the new regulations must have a policy summary that cannot be a part of the policy itself. The summary must be provided to the policyholder at the time of application.
- Policy summaries must contain certain items, such as a listing of the premiums payable and the periods to which they apply, as well as a separate paragraph titled "complaints."
- Summaries other than those specified can be used, but must be filed with the department of insurance at least 20 days before use.
- Each type of policy (i.e., indemnity, Medicare supplement) must have its own summary which identifies the category to which it belongs and summarizes its contents.
- The Medicare supplement summary includes a comparison of benefits form for Medicare Part A and B. It also emphasizes the use of loss ratios (it states the minimum loss ratios allowed by law for policies of this type and the loss ratio of the policy in question).

• The prospective insured has 10 days to review the policy, thirty days if a direct insurer is involved in the sale.

Policy and Rate Filings and Review

• Extensive provisions specify procedures relating to the filing and revisions of policy forms and the maintenance of an up-to-date rate manual.

• Each rate filing must be accompanied by an actuarial memorandum that has been prepared and certified by a qualified actuary. This memorandum must contain among other things: the formulas or methods used to obtain the gross premiums; a list of all assumptions made in the rate filings; the actuarial basis for different rates by sex; the commission scale applied to each form and a detailed list of all other anticipated expenses; the expected claims cost; and, the anticipated loss ratios for the first five years (and more if computed).

Standards for Maintaining Experience Data

• Premiums and loss data must be recorded for each policy form and for each major combination of coverage. The experience data must include: premiums written and paid; each reserve component; earned premiums; paid losses; and incurred losses.

Evaluation Standards

• Any rate will be disapproved unless the aggregate anticipated loss ratio for the period computed meets a certain standard. The minimum loss ratio for policies issued to those 65 and over must be 65%.

MONTANA

The Insurance Department of Montana held a hearing on disclosure requirements relating to the sale of Medicare supplements in 1978 and subsequently adopted a new rule, effective June 1, 1979.

An agent or insurer selling an individual disability (health) insurance policy specifically designed to supplement Medicare insurance benefits must provide a prospective policyholder with the disclosure form outlined in the new regulation—no later than the time of delivery of the policy. The form compares Medicare and insurance policy benefits, provides very basic information about Medicare, and cautions the buyer about reading the policy for details.

Although somewhat vague, the rule evidently does apply to direct insurers. It does not specifically mention hospital indemnity or dread disease policies.

MICHIGAN

Public Act 447 of 1978, which became effective April 1, 1979, establishes *mandatory* requirements for insurers to offer Medicare supplements. Any insurer offering a hospital, medical or surgical expense incurred policy is required to offer a Medicare supplement for sale in Michigan. Procedures and information to implement Public Act 447 of 1978 are contained in Bulletin 79-4. The procedures do not have the force of law but constitute a statement of insurance department policy. Public Act 447 which adds Section 2265 to the Michigan Insurance Code, states in part:

1. "Each insurer offering individual or group hospital, medical, or surgical expense incurred policies shall provide without restriction, to any person who has been insured with an insurer subject to this section at any time during the five year period preceeding application for a supplemental policy, a right of continuation or conversion to a guaranteed renewable or noncancellable supplemental policy which covers, at a minimum, the deductible and coinsurance requirements of a Part A and Part B of the federal Medicare program. . . "

2. "A person not insured under an individual or group hospital, medical, or surgical expense incurred policy as specified in subsection (1), after applying for coverage under a supplemental policy required to be offered under subsection (1), shall be entitled to coverage under a supplemental policy which may include a provision for exclusion from pre-existing conditions for six months after the exception of coverage. . ."

In other words, those persons not already insured are subject to a six month pre-existing conditions clause provision; those already insured are not.

Section 2265 is applicable to most insurers marketing individual or group hospital, medical, or surgical expense incurred policies in Michigan. This includes insurers offering dread disease policies which are written on an expense incurred basis.

The statute specifies that minimum coverage *shall* be offered to *all* persons eligible for Medicare—*without restriction.* Therefore, the insurer MAY NOT:

1. Deny coverage to the applicant;
2. Include a waiting period;
3. Exclude from coverage, by name or specific

description, any disease or physical condition;

4. Specify a maximum benefit or benefit sum within the policy on a single clause or confinement or lifetime basis; and

5. Exclude coverage for a pre-existing condition except when specifically allowed by the statute.

Every Medicare supplement policy must meet several other important standards. These include:

- The policy, at a minimum, must provide coverage for all Medicare eligible expenditures to pay for the deductible and coinsurance requirements of Part A and Part B of Medicare.
- The policy must be guaranteed renewable or noncancellable.
- The policy must provide for automatic adjustments of benefits to correspond to changes in the coinsurance and deductible requirements of Medicare.
- The policy may include a coordination of benefit clause.

Each insurer must certify to the Insurance Commissioner that they are not required to offer a Medicare supplement policy. This certification is made on Form 79041, which is used to collect premium information, every time a rate filing occurs for a Medicare supplement policy.

Michigan rules also have established standards for policy benefits in relation to premiums. They call for a loss ratio of 65 percent for Medicare supplements.

Editors Note: The implementation of P.A. 447 has resulted in a lawsuit. Twenty-two commercial carriers are contesting the law which requires commercial insurance companies to offer Medicare supplementary coverage to senior citizens and disabled persons. Blue Cross-Blue Shield of Michigan has joined the state in defending the new law.

MINNESOTA

On July 1, 1976, Minnesota implemented its Minnesota Comprehensive Health Insurance Act of 1976. The law sets minimum standards for all health care insurance policies (including Medicare supplements); established a reinsurance pool to assure the availability of health insurance to all citizens; requires the review of hospitals and insurance premium rates; and provides protection against catastrophic health care expenses. Any insurer issuing Medicare supplement plans must develop and file with the Commissioner, a Medicare supplement policy that meets the minimum standards set forth in the statute for a "qualified" Medicare supplement plan. An insurer marketing a qualified plan must offer it to "each person who is eligible for coverage and who applies for a Medicare supplement plan."

Although employers may offer "non-qualified" health insurance to their employees, the statute establishes minimum standards for a series of *qualified* health plans, one of which the employer *must* offer to his employees. A *Number Three Plan* is the most comprehensive, while the *Number Two* and *One Plans,* which offer basically the same benefits, have higher overall deductibles. Specifications for a qualified Medicare supplement plan are clearly detailed in Section 62E.07. Minimum standards for Medicare supplements must:

- Be designed to supplement Medicare and provide coverage of 50 percent of the copayment and deductible required under Medicare.
- The policy must cover 80 percent of the charges for services outlined for a Number Three Plan—for services not paid by Medicare.
- The total annual out-of-pocket expense for covered services is limited to $1,000.
- The maximum lifetime benefit must be at least $100,000.

The State of Minnesota, Department of Commerce, has also issued "Proposed Rules Governing Minimum Anticipated Loss Ratios," which applies to all policies or contracts of accident and health insurance written pursuant to Minnesota Statute 60A-06, subd. 1, clause 50. These proposed regulations contain comprehensive, specific instructions regarding filing requirements for each new policy form and each rate revision. If implemented, the rule should generate extensive information for the insurance department to monitor policy history and performance.

A section dealing with the relationship of premiums to benefits set variable loss ratio standards for different types of coverage. Disclosure of the *anticipated loss ratio must be made to the applicant* at the time of application. The proposed regulation calls for the following ratios:

Type of Coverage	Renewal Clause*			
	OR	SR	GR	NC
Medicare Supplement	65%	65%	65%	55%
Medical Expense	60%	55%	55%	50%
Per Diem and Hospital Indemnity	60%	55%	55%	50%
Loss of Income	60%	55%	50%	45%
Other	60%	55%	50%	50%

* "OR" means optionally renewable; "SR" mean nonrenewable for stated reasons only;
"GR" mean guaranteed renewable; "NC" means non-cancellable.

NEW JERSEY

The state of New Jersey has, over the last year, taken several meaningful actions to strengthen its regulations governing the sale of Medicare supplements. Two laws were passed in the 1979 legislative session which should have a significant impact on the marketing of Medicare supplements in that state. One statute, known as Assembly No. 1474, requires the Commissioner of Insurance to issue "minimum standards, including standards for full and fair disclosure, for the form, content, and sale of individual health insurance." It also bans the sale of specified disease policies. Hearings on the regulations to carry out portions of this law were held in August of 1979, and should be adopted in the near future. The state legislature also passed a bill, Assembly No. 3008, on August 6 which provides for simplifying the language used in life and health insurance policies.

Proposed regulations by the Department of Insurance to implement A. 1474, although applicable to many other forms of health insurance, contain important provisions which pertain to Medicare supplements. Under Section 6, minimum standards for hospital confinement income, Medicare supplement, and limited benefit coverage, are established. "Medicare Supplement Coverage" is broadly defined as "a policy of health insurance sold to a Medicare-eligible person, which is designed primarily to supplement Medicare, or is advertised, marketed, or is otherwise purported to be a supplement to Medicare." Some of the minimum standards for Medicare supplements include:

- No benefits of a policy can duplicate benefits provided by Part A & Part B of Medicare.
- Mandatory coverage of the Part A deductible.
- Coverage of all Medicare eligible expenses for hospitalization not covered by Medicare from the 61st-90th days, and for Medicare's lifetime inpatient reserve days.
- After use of all hospital benefits, the policy must pay 90% of all Medicare Part A eligible expenses for hospitalization not covered by Medicare for an additional period of not less than 365 days.
- SNF coverage for services not covered by Medicare from the 21st through the 100th days.
- Coverage of 20 percent of Medicare-eligible expenses under Part B, regardless of hospital confinement, with a maximum deductible of $200 and a maximum benefit of at least $5000 per calendar year.
- Benefits designed to cover the cost-sharing amounts under Medicare will be changed automatically, however, policy premiums may *not* be charged to correspond to such changes.
- A six-month pre-existing clause provision.

The *proposed* regulation is also very comprehensive and detailed in its disclosure requirements that apply to the sale of all individual health insurance policies. Among the many provisions, the regulation calls for:

- The buyer usually has a 10 day "free look" period to return the policy if not satisfied. For those policies issued by mail, the right to return period is extended to 30 days.
- "A Shopper's Guide to Life and Health Insurance for Senior Citizens" *must* be furnished to each Medicare eligible person in connection with the purchase of a policy providing hospital-medical expense or hospital indemnity benefits (with certain exceptions). The Guide is provided at the time of application, or at delivery, in the case of direct response insurers.
- Every individual health insurance policy must be accompanied by the "appropriate outline of coverage" detailed in Sections 8 (c) through (n). Like the Shopper's Guide, the outline must be made available to the applicant at the time of application and at delivery for the direct response insurers.
- Each kind of insurance (i.e., basic hospital expense coverage, basic medical-surgical expense coverage, etc.) has its own specific Outline of Coverage. In an interesting innovation, New Jersey requires *separate* forms for most categories for Medicare eligible persons. For example, there is a form for Hospital Confinement Income Coverage for Medicare eligible persons. They also have specific forms for Medicare supplements, and limited benefit health coverage for Medicare eligible persons. The regulations clearly set out the form, content and use of the Outline of Coverage for *each kind* of health insurance.
- Like Colorado, one section of the proposed regulations calls for the insurer to inquire about the existence of current coverage and to obtain a statement, dated and signed by the applicant, regarding the specifics of this insurance. If an agent finds the sale will involve replacements, the prospective buyer must be provided with a notice, as outlined by the regulation. A direct insurer is also required to issue a separate, clearly defined notice along with the policy at delivery. A similar procedure is followed to warn applicants if the sale will result in the duplication of insurance.

In another subchapter of the proposed regulations, Individual Health Insurance Rate Filings, the Commissioner of Insurance is provided with broader powers to review and approve individual health insurance policies. When apply-

ing for new or revised rates, each insurer will be required to submit: 1) A completed Individual Health Insurance Rate Report; 2) An actuarial memorandum which details the anticipated loss ratio, specific formulas and methodology for calculating gross premiums, and several other items; and 3) For rate revisions, a statement of the reasons for the revision and an estimate of the expected average increase or decrease in premium both in dollars and percent.

The section also sets standards for loss ratios. For any over 65 coverage, the ratio must be at least 65%. However, if it can be shown that the standard cannot be attained, a lower loss ratio may be permitted.

The second law recently passed by the state legislature, Assembly No. 3008, is entitled the Life and Health Insurance Policy Language Simplification Act. In attempting to make insurance policies more readable, the bill establishes several minimum standards, including:

- A minimum Flesch test readability score of 40, or other similar tests approved by the Insurance Commissioner.
- Policies must be printed in at least 10 point type, one point leaded (with some exceptions).
- The style, arrangement, and appearance of the policy can give no *undue prominence* to any portion of the text, or to any endorsements or riders.
- The policy must contain a table of contents or an index of the principal sections of the policy, for any policy either more than three pages in length or less than three pages but more than three thousand words.

The law applies to most policies, but excludes policies subject to federal regulations, group policies covering fifty or more people, and certain others. In other words, the law applies only to small group and individual policyholders who are not self-insurers. When filing a policy with the Commissioner, the insurer must include a certificate stating the policy meets the test readability requirements.

NEW MEXICO

New Mexico implemented a disclosure rule governing the sale of individual Medicare supplement policies on November 28, 1977. It does not affect the sale of hospital indemnity or dread disease policies to Medicare eligibles, nor does it cover mail order sales to New Mexico residents by *unlicensed* out-of-state insurers.

Like many other states, New Mexico requires that a summary of federal Medicare benefits and policy benefits be furnished to the applicant either at the time of application, or no later than at the time the policy is delivered. The disclosure forms are fairly standard and provide several columns to compare Medicare and policy benefits. They also must contain a description of other benefits, exceptions, reductions and limitations contained in the policy, and the name and the address of the insurer. The New Mexico form does not attempt to warn Medicaid eligibles about purchasing Medicare supplements or inform the potential buyer about the use of pre-x clauses. It also does not make any mention of the kind of expenses not covered by Medicare or the remaining out-of-pocket expenses to the insured.

NEW YORK

Through its Minimum Standards for the Form, Content and Sale of Health Insurance, including Standards for Full and Fair Disclosure (Amendments to Regulation 62), New York supervises the sale of all kinds of private health insurance. Although the regulations do not specifically promulgate separate rules for Medicare supplements, it contains important provisions which impact on the sale of health insurance to senior citizens. Portions of the regulation call for:

- Prohibiting the sale of specified disease policies, or coverage for procedures or treatment unique to specified diseases.
- Using the appropriate disclosure form for individual accident and health insurance policies, and for *certificates of insurance* covering persons who reside in the state, when used in conjunction with a group accident and health insurance policy delivered or issued for delivery in the state. Separate disclosure forms are available for: Basic Hospital Insurance policies, some Medical Insurance Policies, Major Medical Insurance Policies, Limited Benefits Health Insurance Policies, Disability Income Insurance Policies, and others.
- Requiring each disclosure form to use a series of questions to clearly state that the policy "covers" or "does not cover" a particular service or provides a certain benefit.

Extensive use is also made of blanks on the form which specify *important* information about things such as room rates, physician fees, and the cost of various kinds of services. The format of these forms is unique and should be reviewed by other states when attempting to revise their own disclosure requirements.

- Requiring a statement on each disclosure form stating the anticipated loss ratio of the policy to be purchased.
- Establishing loss ratios for various forms of insurance, including a loss ratio of 60 percent for policies issued to persons aged 60 and over.

OHIO

Ohio's Rule 3901-1-35, Solicitation and Sale of Medicare Supplemental Accident and Health Policies, became effective January 1, 1979. The rule attempts to protect the interests of senior citizens by clearly defining "unfair or deceptive acts" in the solicitation and sale of individual Medicare supplement policies. It does not apply to group, blanket, or franchise accident and health insurance.

Much of the regulation is clearly directed towards eliminating various misrepresentations by agents, especially in claiming some sort of affiliation with or sponsorship by the federal government or its agencies. The rule specifies that no agent can claim to have access to records of the government agencies such as the Social Security Administration. Among the provisions, the regulation specifically prohibits any misrepresentation or incomplete comparison of benefits that might lead a person to purchase new coverage, or change or surrender existing coverage.

OREGON

Oregon has taken a number of actions to impose limitations on the sale of Medicare supplements. In March of 1977, Oregon implemented a disclosure rule that mandates the use of a two-page disclosure form. More recently, the legislature passed a bill setting minimum loss ratio requirements for Medicare supplement policies.

The Oregon disclosure requirement, set out in Chapter 836, Sections 52-105 and 52-110 of Oregon's Administrative Rules, is similar to those in several other states. It calls for any agent or insurer selling Medicare supplemental insurance to deliver the disclosure form to the insured no later than the time of delivery. Either the agent or the insurer is instructed to complete and sign the form.

Page one of the form consists of three columns: one deals with Medicare benefits; another explains what portion Medicare will pay; the third is a series of blanks describing the policy's benefits which the insurer or agent is supposed to complete. The second page provides general information about Medicare supplemental insurance, including warnings about physician charges, pre-existing conditions, and the purchase of policies by Medicaid-eligibles.

The rule is strictly a disclosure requirement and does not prescribe any minimum standards or attempt to establish categories of Medicare supplements. Although applicable both to group and to individual insurance, it is silent regarding its applicability to mail order insurers. Indemnity, nursing home and dread disease policies sold to the elderly are not governed by the regulation.

Senate Bill 855, just passed in the 1979 legislative session, authorizes the commissioner of insurance to issue rules which establish minimum benefit standards for Medicare supplements; requires the ratio of benefits to premiums to be not less than a specified percentage in order to be reasonable (60%); requires the periodic filing of data that will demonstrate the insurer's compliance; and, establishes requirements intended to discourage duplication of overlapping of coverage and replacement of existing policies by new policies.

PENNSYLVANIA

Pennsylvania has an "Individual Accident and Sickness Insurance Minimum Standards Act" which was passed May 18, 1976. Known as P.L. 123, No. 54, it established broad standards for policy provisions, minimum standards for benefits, the form and content of an outline of coverage, the use of a pre-existing condition clause, and many other provisions relating to the content and sale of various kinds of individual accident and sickness insurance policies.

Authors Note: Copies of the law and the regulations to implement the law had not arrived as this report nears completion. According to conversations with insurance officials in

Pennsylvania, however, regulations are in force now which establish minimum benefit standards, a disclosure form used in sale of Medicare supplements, hospital indemnity and dread disease policies, and Flesch test readability standards. Insurance officials feel their effort has exceeded the standards set by the NAIC in several respects and are waiting to evaluate the effectiveness of their regulations before undertaking additional major revisions.

SOUTH DAKOTA

Beginning October 1, 1979, South Dakota will require the use of a Medicare supplement disclosure form under Chapter 20:06:13 of its insurance code. The rule stipulates that the form shall be furnished to "any applicant for insurance designed to supplement Medicare on or before the delivery of the policy." Therefore, the regulation will apply to the sale of group and mail order insurance, as well as individual policies.

General information preceding the comparision-of-benefits section of the form briefly cautions the prospective policyholder by:

- Noting that the form is for disclosure purposes only and not a part of the policy and that Medicare benefits change so the figures cited may not be applicable in the future;
- Warning that purchasing several policies may be a waste of money due to duplication of coverage;
- Advising the insured that policy benefits (coinsurance and deductibles) are paid *only* up to the Medicare approved level and, therefore, the policy holder may be required to pay the difference between approved and actual charges;
- Telling the insured to check to see whether a nursing facility is Medicare approved. It does not mention that Medicare *never* pays for custodial care.
- Asking a series of clear, brief questions regarding the coverage provided by the policy including renewability, preexisting conditions and waiting periods.

UTAH

The Utah State Legislature passed HB187 in the 1979 legislative session which enacted Sections 31-44-1 through 31-44-8 of the Utah Code. This basic enabling legislation applies to all individual accident and health insurance, but includes important provisions relating to the sale of Medicare supplements. The law directs the Commissioner to adopt rules and regulations that: establish minimum benefit standards for various kinds of coverage including basic hospital, basic medical-surgical, hospital indemnity, disability income, specified disease or specified accident, Medicare supplement, and limited benefit coverage; present the content and format of the outline of coverage; present the method of identifying policies and contracts based upon coverage provided; and prescribe procedures for suspending or withdrawing approval of a form if the benefits are unreasonable in relation to the premium charge.

The statute also *allows* the Commissioner to adopt certain rules and regulations which establish disclosure requirements for Medicare supplements (and other forms of insurance) and provides a standard form for the content of an informational brochure or buyer's guide to be used in the sale of Medicare supplements. Both the disclosure form and informational brochure must be delivered to the prospective applicant—except for direct response insurers. Mail order issues are required to provide these materials no later than the time of policy delivery. Among other things, the disclosure form must contain: a description of the principal benefits and coverage; a statement of the exceptions, reductions, and limitations contained in the policy; a statement of the renewal provisions; and a statement that the outline is a summary and that the policy should be consulted to determine contractual provisions.

The regulations to implement HB187—which establishes a minimum standard for Medicare supplements—are in the process of adoption as this report is nearing completion. According to insurance department officials, they should be adopted sometime in the Fall of 1979.

WASHINGTON

The state of Washington enacted its Medicare disclosure requirements, WAC 284-50-45 through 65, in August of 1978. It is very similar in scope and content to the disclosure requirements imposed by other states. However, Washington's disclosure form does contain a few notable components not always included in other states' forms. These include the following:

- Comments and suggestions from the Insurance Commissioner precede a comparison-of-benefit chart.
- Medicaid-eligibles are advised not to buy Medicare supplements.
- Potential purchasers are urged to use the form to compare a policy's benefits with any policies already in force.
- The comparison chart clearly indicates that Medicare does not pay for care after the 100th day of care in a skilled nursing facility and/or for any custodial care.
- The comparison chart also includes a section for miscellaneous services or benefits which list some items *never* covered by Medicare.
- The disclosure form requires a clear statement of the premium amount and disclosure of whether the premium can be increased unilaterally by the insurance company when the policyholder reaches a certain age.

The regulation applies only to individual health insurance policies—not to group or mail order insurers. Dread disease and hospital indemnity policies also are not covered by the rule.

The comparison-of-benefits section of the form consists of two columns, one explains Medicare benefits, while the other outlines what the policy pays. There is no space or section that examines what expenses must be paid directly by the policyholder. The form, by repeatedly underlining key words such as "Medicare approved" and "Covered," attempts to stress the limitations of Medicare benefits.

The last section of the disclosure form includes a statement about the premium cost and discloses whether the premium can be raised unilaterally by the insurance company at a certain age. Other information such as the date the form is completed, the policy form number and the *printed* and *signed* name of the agent are placed at the end of the form.

WISCONSIN

The State of Wisconsin, with the implementation of Ins. 3.39, assumed a leadership role in instituting meaningful reforms in the sale of private health insurance to the elderly. The rule established both unique minimum standards and disclosure requirements for Medicare supplements. However, only individual Medicare supplement policies, not group coverage or conversion contracts, are affected by the regulation.

Effective January of 1978, Ins. 3.39 calls for the establishment of four clearly defined categories of Medicare supplement insurance and minimum levels of coverage for each category. All policies approved for sale in Wisconsin must adhere to the standards for one of the four classes of coverage. Any policy not meeting these standards can still be sold in Wisconsin. However, no such policy can be marketed as a supplement to Medicare.

All approved Medicare supplement policies carry a label or designation on the first page which clearly identifies the policy category. Designations range from the most comprehensive (Medicare Supplement 1) to the least comprehensive (Medicare Supplement 4). Each policy also contains a "caption" which explains the four classes of coverage and advises the purchaser to consult the Commissioner's information pamphlet "Health Insurance Advice for Senior Citizens." The booklet must be provided with the application for all Medicare supplement policies, and other accident and sickness policies sold to Medicare eligibles.

Any Medicare supplement, like other categories of policies, is required to cover only those expenses normally covered by Medicare. Although companies may elect to offer a policy to cover initial deductibles under Part A and Part B of Medicare, coverage of initial deductibles is not mandatory. The minimum coverage provided by a Medicare Supplement 1 include:

- Coverage of all Medicare eligible expenses (as listed in 3.39) to a maximum of $22,500 per benefit period (inclusive of Medicare Parts A & B); or
  $15,000 per benefit period for Medicare Part A and
  $7,500 per calendar year for Medicare Part B.
- Part A eligible expenses of: hospitalization including 60 lifetime reserve days; services in SNF; post-hospital home health care; blood.

• Part B eligible expenses of: physicians services (except for routine physicals); home health care; outpatient hospital service (ER, outpatient clinic, lab tests, x-rays, medical supplies, certain drugs); outpatient physical therapy and speech pathology services; and other health services and supplies such as ambulance and prosthetic devices.
• 75 percent of prescription drug expenses and 50 percent of psychiatric treatment up to a lifetime maximum of $1000.

The requirements for Medicare Supplements 2 and 3 policies are quite similar to those mandated for the Medicare supplement 1 category—except that minimum dollar limits are reduced and some coverage is no longer required. For example, a Medicare Supplement 2 policy does not require the coverage of prescription drugs and psychiatric services, among other things. The Medicare Supplement 4 category is subdivided into two parts. Medicare Supplement 4A "provides substantial coverage for hospitalization and other Medicare *Part A expenses only*—to at least a stated maximum of $15,000 per benefit period." A "Medicare Supplement 4B covers all Part B Medicare eligible expenses (listed) to at least a stated maximum of $7,500 per calendar year, and allows a deductible of $500 of Medicare eligible expenses per calendar year."

Any Medicare Supplement policy must clearly state in its "Outline of Coverage" that the policy will cover only Medicare eligible expenses in a Skilled Nursing Facility approved by Medicare. The Rule also requires a clear statement to the effect that neither *Medicare* nor the *policy* will pay for custodial care. All Medicare supplement policies, except for 4B, must offer 30 days of skilled nursing care; and may not exclude coverage because a nursing facility is not Medicare certified.

The Disclosure Requirements of 3.39 are quite extensive. As noted, an 18 page informational booklet must be provided to prospective insureds at the time of application. The pamphlet is well done and relates a great deal of useful information to the purchaser regarding Medicare, private health insurance and the four categories of Medicare supplements. Agents also are required to leave an "Outline of Coverage" with people purchasing a policy—a chart which compares Medicare benefits to policy benefits and notes the remaining out-of-pocket expense to the purchaser. The outline of coverage does not have to be signed by the applicant.

VI. A SURVEY OF STATE INSURANCE OFFICIALS

In an effort to present a relatively comprehensive review of current state activities and attitudes on the sale of private health insurance to the elderly, the IHPP conducted an independent survey of the state insurance departments. This telephone survey was conducted during the months May through August of 1979. Individuals responding to the survey were generally high-level departmental officials responsible for health insurance, including several Commissioners. Forty-two of the fifty states responded to the survey. Chapter V of this study reported on the actual laws or regulations about the Medigap problems now being considered or in force in these states. The following material summarizes state officials' attitudes and opinions about the problem. A more detailed breakdown of survey results found in Tables 5 and 6 found in the Appendix.

GRAVITY OF MARKETING PROBLEMS

State insurance officials do consider the sale of private health insurance to the elderly to be a problem in their states. Although only 43 percent of the respondents classified marketing abuses as a *major* problem, the vast majority of the remaining 24 states indicated they faced a "serious" or "continuing" problem. Most officials seemed more concerned with the *way* the insurance is marketed to the elderly than the coverage provided by the various kinds of Medicare supplements, dread disease, and hospital indemnity policies. Very few officials perceived marketing problems as getting any worse in their states. Only six states indicated that marketing problems were intensifying, seventeen felt they were improving, and sixteen thought they were staying about the same.

Insurance officials cited a number of reasons for improved market conditions in their states. Some states (Washington, Oregon) pointed to better disclosure requirements. Other states (Oklahoma, Arkansas, Utah) felt publicity generated by Congressional hearings and local insurance company activities had resulted in a better informed public and a more cautious insurance industry. Still other states saw stricter enforcement of advertising regulations (South Carolina), prosecutions of agents (Kansas, Kentucky), and an enlarged investigative staff (Arizona) as factors which helped to curb Medigap abuses.

STATE INVESTIGATORY ACTIVITIES

California and Illinois were among those few states that have conducted an examination of Medigap problems. Sixteen insurance officials, however, indicated that their insurance departments have held "in-house" investigations on the sale of private health insurance to the elderly. Occasionally, outside entities such as the Consumer Protection Board (New York) or the Attorney General's Office (New Jersey) have played a prominent role in investigations that were undertaken.

After a complaint or a series of complaints has been received, most investigatory activity by insurance departments is handled on a case-by-case basis. This is usually accomplished by calling a particular company or agent in to meet with insurance department officials. State officials felt this "continuing" kind of investigation is the most effective way to focus attention on those agents or companies directly responsible for the majority of abuses and to eliminate further problems.

NEED FOR MEDICARE SUPPLEMENT LEGISLATION

Only 26 percent of the insurance officials contacted saw a need for new specific Medicare supplement legislation. Usually, these officials came from states where current statutes were inadequate and, in some cases, did not allow the Commissioner sufficient authority to control the insurers through the regulatory process. Seventy-four percent of the officials felt their insurance statutes were adequate to deal with Medigap abuses. Most believed instituting reforms through the use of departmental rules and regulations was more effective than statutory reform and afforded them more flexibility in revising regulations to correspond to local needs.

This attitude that Medigap problems can be handled within existing statutes and rulemaking authority is a strik-

ing contrast to federal investigators, who emphasized that only six states had enacted specific state Medigap laws and had thus abrogated their responsibility in this area. In fact, although only a few states have specific laws, at least 18 have laws or regulations designed to deal with the Medigap problem.

POSSIBLE IMPACT OF NAIC MODEL RULE

As noted previously, many states have been waiting for the NAIC to finalize and adopt its new model regulation regarding Medicare supplements. Sixty-six percent of the officials responding to the survey believed the model regulation will result in either new legislation or regulation in their respective states. Ten officials saw no immediate changes forthcoming at the state level, while four states reported that it was too early to comment on possible actions for the coming year.

In those states expecting changes, eighteen saw reforms coming as new regulation, while six states thought a new Medicare supplement law was a possibility. Several states did not know what form the changes would take.

In those states anticipating a statutory or regulatory change, most (22) indicated they would attempt to further standardize the Medicare supplements marketed in their states. Seventeen states plan to establish minimum ratio standards. Establishing minimum benefit levels for Medicare supplements was mentioned as a possible course of action by fourteen states. Twelve states—most of which currently have minimal restrictions on the use of pre-existing clauses —plan to strengthen their regulations governing pre-x clause requirements in the coming year. Although thirty-three of the responding states currently have a "free look" period after a policy is received by the purchaser (usually 10 days), six states plan to extend this period, some to thirty days.

FEDERAL INVOLVEMENT IN REGULATING INSURERS

State insurance officials did not think the federal government could do a more effective job of regulating health insurers than the states. Only five out of forty-two individuals responding to the survey thought federal involvement in Medigap issues, such as issuing federal minimum standards on Medicare supplements, would be helpful to the states in regulating insurance companies or assisting the elderly. Eighty-eight percent believed states have adequate resources to deal with the majority of problems and needed to retain the authority and flexibility to formulate policy and actions at the state level.

Several insurance department representatives felt the federal government should take some steps to help eliminate the problems surrounding the sale of Medicare supplements, but thought federal efforts should be directed toward correcting basic deficiencies in the Medicare program itself. There were two frequent suggestions. The first was to limit the deductible and coinsurance requirements of Medicare. This would save the elderly more out-of-pocket expense and reduce the pressure to purchase supplemental insurance to cover these items. The second frequent suggestion was to make assignment of Medicare mandatory, or limit the amount doctors can charge patients above what Medicare will reimburse for a particular service. Several officials thought the federal government might also develop and market its own Medicare supplement policy.

COMPLAINTS TO STATE INSURANCE DEPARTMENTS

State insurance officials cited an array of basic reasons for marketing abuses. Using numbers of complaints to their insurance departments as indicators, officials saw problems resulting primarily from: 1. Agent misrepresentation and abuse; 2. The elderly's lack of understanding of Medicare and insurance policy coverage; 3. Claims payment disputes, including delays in payments; and, 4. Overselling and unnecessary replacement of insurance policies.

It should be noted that insurance officials did not generaily maintain separate complaint files for elderly policyholders. Complaints from senior citizens usually are filed with all other accident and health complaints. As a result, the most frequently cited reasons for complaints were based on the experience of officials who have worked with the elderly population over a number of years, rather than raw information.

Despite the lack of hard evidence, many state officials (29%) believe the number of complaints from those over 65 is increasing.[46] They attribute the increasing number of complaints to the publicity Medigap problems have been receiving in the press and to the individual efforts of the insurance departments to make senior citizens more aware of problems in the health insurance marketplace.

Different types of insurance policies sold to senior citizens were identified as causing the most problems in several states. Medicare supplements were singled out as the largest cause of complaints in 13 states. Hospital indemnity policies generated the most problems in an additional eight states, while dread disease policies ranked as the chief source of difficulty in eight more states. Officials from 13 states did not see any one kind of private health insurance creating more problems or complaints than any other kind of insurance sold to the elderly.

PROBLEMS IN DOCUMENTING AND PROSECUTING ABUSES

Of those responding to the survey, sixty-two percent of the state officials felt they had a problem in documenting and prosecuting Medigap abuses. Most of these officials said they did not have adequate resources (money and personnel) to do a good job of following-up on complaints, establishing patterns of abuse, and building a good case to prosecute an agent or company. They were particularly concerned about the lack of a sufficient number of trained insurance investigators.

Persuading senior citizens to testify and getting reliable witnesses were the other major problems facing state insurance officials. They noted that the poor health of an elderly person or the possible strain of a trial often made those over 65 reluctant to testify. They also indicated that senior citizens were hesitant to make any trouble for "that nice young man," especially if the company had arranged to return the premiums on their policy. The problems of prosecution are amplified because Medigap cases hinge upon the testimony of one person—the policyholder—against that of another person—the agent—which results in an increased emphasis on cross-examination.

Several officials, including those from Nebraska and North Dakota, also felt their laws were inadequate and restricted the ability of the insurance department to prosecute offenders.

In spite of prosecution difficulties, at least 7 states (Florida, Kansas, Kentucky, New Jersey, Pennsylvania, Rhode Island, and Texas) had fined insurance companies for marketing abuses in the last year. Over twenty-one states had either revoked or suspended the licenses of agents during the same period. Almost all officials agreed that increased efforts to enforce insurance regulations, and to prosecute offenses when possible, were having a very positive affect on the marketing practices of insurance companies and their agents.

STATE INFORMATION AND DISCLOSURE ACTIVITIES

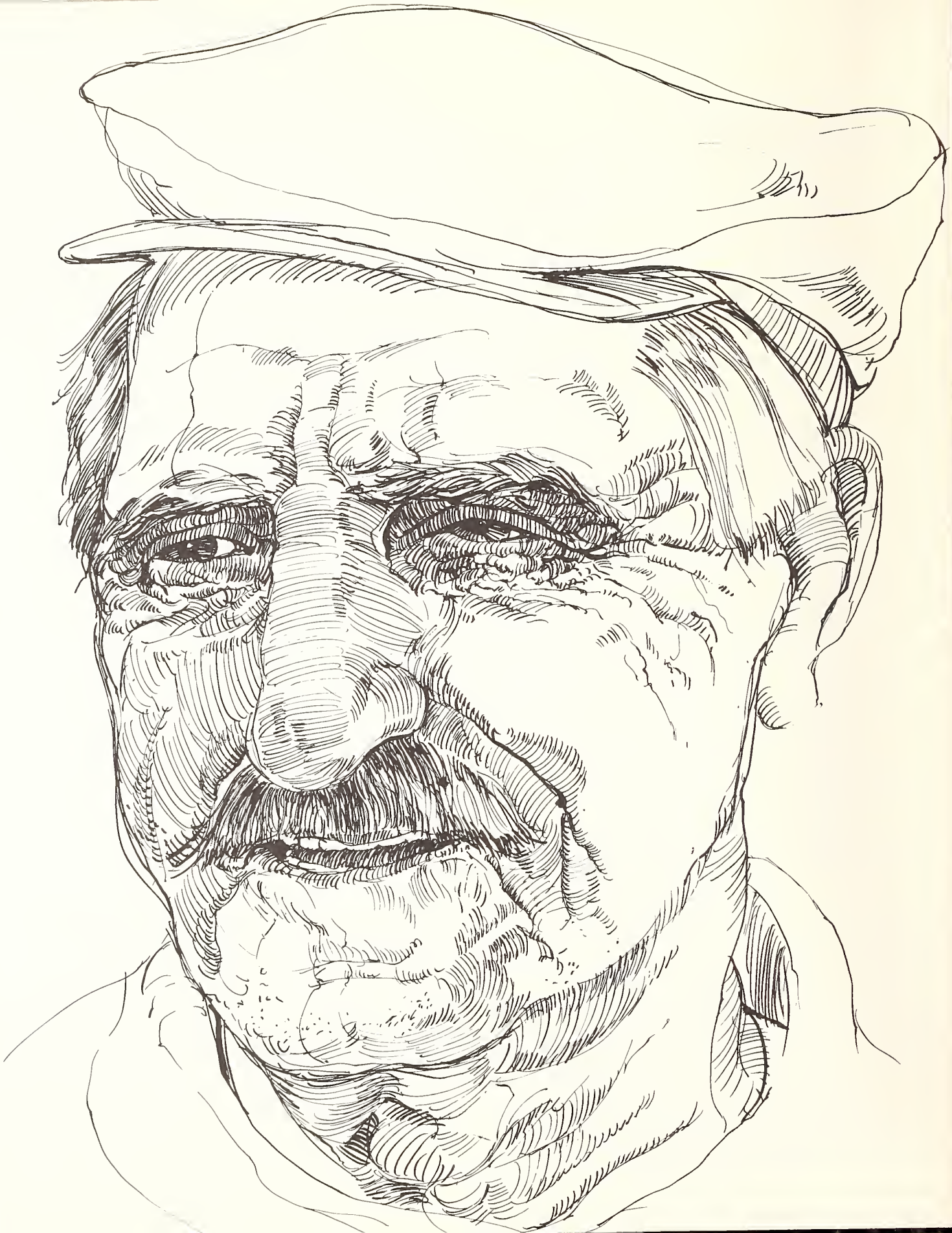
Many states were working to strengthen their consumer information activities and disclosure requirements. Twenty-one (50%) of those states contacted have a consumer information pamphlet on health insurance available for use by senior citizens. Only a few of these states, however, mandated the use of this pamphlet, either at the time of sale (Wisconsin) or at the time of delivery (Michigan). Information booklets were usually made available to senior citizens through general distribution channels, such as senior citizens' organizations, or upon request. Many other states (South Carolina, Vermont, West Virginia) anticipated developing a brochure to be patterned after the new NAIC buyer's guide.

At least nine of the states contacted mandate the use of a form which outlines benefits and gaps in coverage. Several of these states, including California, Colorado and Pennsylvania, require the use of this form for all types of health insurance sold to the elderly. New Hampshire and New Jersey, which outlawed the sale of dread disease policies, limit the form's use to Medicare supplements and hospital indemnity policies. Washington, Oregon and New Mexico require the form's use only for Medicare supplements. Several other states may soon be implementing new disclosure regulations which require the use of a disclosure form (Illinois, Montana, and Utah). Many other states (North Carolina, South Carolina, and Vermont) plan to have disclosure request forms in place in the very near future.

Most of the states contacted plan to take other steps which will make it easier for senior citizens to read and understand policies. Over 50 percent of the states responding to the survey already have systems of labeling policies or regulations which govern policy simplification. Many insurance officials were particularly interested in requiring Flesch Test readibility standards for insurance policies.

As for other informational activities, seventy-one percent of the insurance departments contacted use a variety of methods to inform the elderly about their insurance needs. Most departments have a "speakers bureau" which discusses health insurance matters with groups of senior citizens on a regular basis. Insurance officials also noted extensive use of the news media to make senior citizens aware of specific instances of marketing abuses or to impart general information about health insurance. Twelve states had no programs to educate citizens about their health insurance needs.

Sixty-five percent of the states contacted had a toll-free number or "hot line" that senior citizens could use to ask questions or register complaints. The toll-free numbers are often provided through or with other governmental offices such as the governor's office, the attorney general's office or the Department of Aging. Insurance officials were generally enthusiastic about the use of the senior citizens' hot line and felt it made it much easier for the elderly to get the help they needed. Several officials, however, stressed that help should be available on an around-the-clock basis (some used recorders).



VII. OPTIONS FOR STATE ACTION

There are many options available to both federal and state policymakers in resolving the problems surrounding the sale of private health insurance to the elderly. Since the NAIC recently adopted regulations to amend the Model Individual Accident and Sickness Minimum Standards Act, at least large-scale federal intervention into the states' regulatory affairs seems unlikely at this time. However, comprehensive and forceful action by individual states, and by the states as a whole, will be necessary to not only retain the traditional role of the states in regulating health insurers, but to curb the unnecessary purchase of health insurance by the elderly.

Testimony presented at the Congressional Hearings on Medicare supplements over the last couple of years has enumerated a wide range of actions states can take to address this complex problem. Some proposed actions like those requiring major changes in a state's insurance statutes and regulations (e.g., Wisconsin, California) would necessitate significant committments of time and resources to evaluate, design and successfully implement. Other possible actions are relatively simple and would entail little more than strengthening existing regulations. As noted, however, any modification or improvement in state statutes or regulations will have to be accompanied by a greater effort to enforce the regulations once in place. Possible actions by states can be broken down into five general areas: • Investigation of private health insurance; • Insurance policy benefits and content; • Insurance agent activities; • Insurance company activities; and • Consumer information activities and disclosure.

1. Investigation of Private Health Insurance

Most states have not yet thoroughly investigated the problems of marketing private health insurance to the elderly. Many states, especially those which feel they have a significant number of marketing abuses, might want to initiate a comprehensive study on the subject before instituting reforms in their insurance statutes or regulations. Such a study would be most helpful in generating useful information about the severity and scope of the problem in a particular state. It would also help insurance officials and legislators establish priorities for action and provide needed information which could be used to inform elderly consumers about the private health insurance industry and marketplace. Such a study might include:

- A comprehensive examination of all companies selling health insurance to those over 65 in the state, including claims handling experiences, denial of claims rates, complaint handling experieces and procedures, and loss ratios of Medicare supplement, indemnity, and dread disease policies. Special attention might also be given to present and future needs to monitor policies, such as establishing systems to obtain accurate data on premium value, number of sales, and payout on all policies sold to the elderly. A review of premium rates and rate increases and the feasibility of mandating prior review of these rates by the insurance commissioner should also be part of any comprehensive examination by a fact-finding body.
- An investigation of mail order insurers, the specific problems covered by this kind of insurance and possible methods to curtail or eliminate mail order abuses.
- A survey of the aged to determine current patterns of health care expenditures, their understanding of Medicare and private health insurance, and the need for insurance benefits and protection, as perceived by those over 65. This survey would also help explore and document the extent of agent/company misrepresentation and abuse, and help define the informational needs of the elderly when making decisions regarding the purchase of health insurance.
- A thorough review of all current statutes and regulations in effect in that state to ascertain how they vary from NAIC model regulations and effective regulations in other states.
- Formal hearings to give individual citizens, public and private sector organizations, and insurance companies the opportunity to discuss their views on a wide range of issues and possible solutions.
- An examination of new and relatively untested methods of evaluating and ranking both insurance companies and their policies. These include the use of *unit pricing,* a kind of disclosure which would make each insurer identify the premium cost of filling each gap in Medicare, and *cost*

indexes, a comprehensive system of ranking a policy's value to its holders (i.e., claims service, complaint handling, underwriting standards and practices, and benefit analysis). New York recently devised a method to rank health insurance policies which might be useful to states as they begin to explore the merits of this approach.[48]

2. Insurance Policy Benefits and Contents

This broad category contains many of the most comprehensive and significant steps a state could take to resolve Medigap abuses. Basically, it entails defining what kind of insurance can be sold, the kind and scope of benefits policies can provide and the provisions policies can contain. Some of the more important suggested state actions include:

- Establish minimum loss ratios for Medicare supplement policies, limited policies, and dread disease policies and make this information available for public use. The "benchmark" loss ratio for Medicare supplements established by the NAIC is 60 percent.
- Establish uniform pre-existing clause provisions to eliminate uncertainty and confusion for the policyholder and to curtail unjustified denial of claims by insurers. Pre-x clauses could also be limited to six months or a year from the treatment of a condition or from the effective date of a policy.
- Require Medicare supplements to cover at least portions of *both* Part A and Part B of Medicare which would help standardize policies and reduce the practice of buying more than one Medicare supplement policy.
- Establish a "no right loss of cancellation" or a "free look" period of 15-30 days.
- Adopt appropriate policy simplification standards which require minimum Flesch test readability scores, minimum standards for type face, and other similar provisions to make policies more readable and understandable by the elderly.
- Adopt, as part of their Minimum Standards Act, standardized definitions of terms used in an insurance policy.
- Develop a clear system of labeling policies which identifies each kind of insurance sold to the elderly as a Medicare supplement, a limited policy, or a dread disease policy. Those policies which are not true Medicare supplements should be labeled accordingly.
- Establish minimum benefit levels for Medicare supplements. Using Wisconsin as a model, states can devise a structure which classifies Medicare supplements according to minimum benefits offered and minimum dollar limits. Companies could be allowed to *exceed* minimum benefits to provide additional coverage at each benefit level.
- Establish descriptive categories which indicate the scope of coverage of a Medicare supplement without rating them. This is comparable to California's use of three categories to describe Medicare supplements.
- Implement unit pricing Medicare supplements to identify the premium cost for filling each gap.
- Set *minimum dollar limits* on the maximum amounts both Medicare supplements and the more limited kinds of policies are required to pay per spell of illness, premium period, etc.

3. Regulate Insurance Company Activity

There are many possible steps states can take to monitor and control insurance company activities, making them more accountable to state regulatory authorities. Some of the more important possible actions include:

- Implementing regulations which stipulate that each policy and all policy riders must be submitted to and approved by the insurance commissioner prior to sale in the state.
- Authorize the insurance commissioner to review and approve the premium rates and rate increases on all insurance sold in the state.
- Strengthen current advertising regulations to require approval of all ads and marketing materials by the insurance commissioner prior to use by the insurance companies. If possible, this should include out-of-state, mail order insurers.
- Prohibit insurance companies from making cash advances to agents against future commissions.
- Mandate submission of an actuarial report which specifies the yearly anticipated loss ratio of a new policy.
- Require each company to have a toll free telephone number for its policyholders.
- Institute stronger underwriting standards. Each company could be required to run a *name* and *address* check on all new policies written by the company.
- Establish strict screening procedures companies must use before hiring or contracting with individual agents.
- Require insurance companies to maintain comprehensive and accurate files on each agent and to report all reasons for an agents dismissal—not just "non-production"—to the insurance commissioner.
- Require insurance companies file their agent training programs with the insurance commissioner. The insurance department could monitor these training sessions on a regular or periodic basis. The state could also mandate that companies provide approved continuing education programs for their agents.
- Formulate statutes or regulations which clearly specify that insurance companies are responsible for the actions of their agents, including independent contractors. Companies could also be required to implement programs to monitor and police their agents.
- Develop and impose meaningful sanctions (i.e., large fines) against insurance companies when their agents are found to use fraudulent or deceptive practices. Often com-

panies are merely required to refund the premiums already paid on a policy rather than pay any additional penalties or restitution to the policyholder or legal authorities.

4. Regulate Insurance Agent Activity

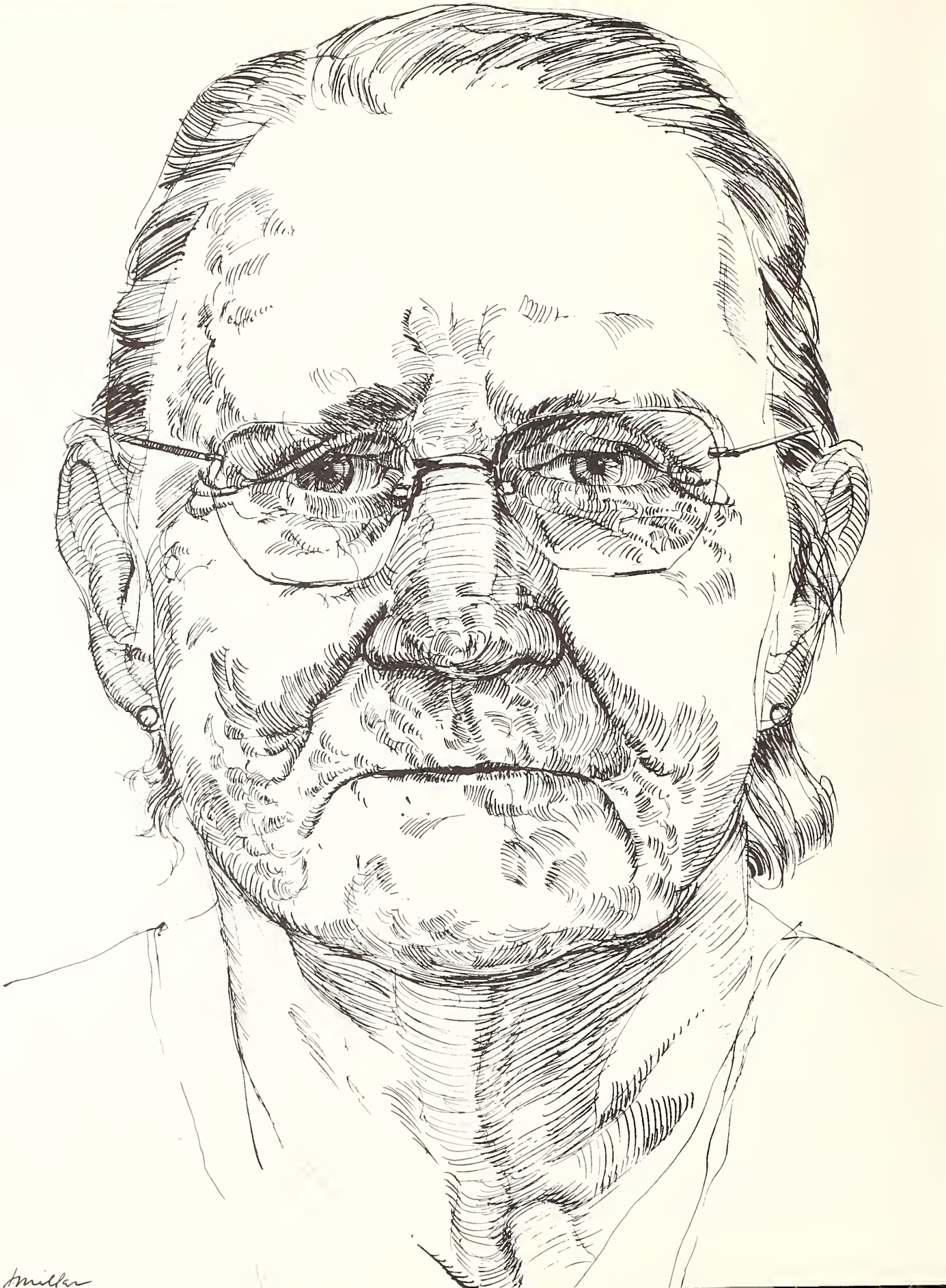
Insurance agents, like their companies, can be made more accountable for their actions. The large number of agents selling insurance make it most difficult for their companies and state authorities to monitor their behavior. Therefore, it is important that states take action to regulate agent activities more closely and to impose stronger sanctions against those agents perpetrating marketing abuses. Some suggested methods for curbing agent abuse are as follows:

- Institute minimum education, training, and moral fitness requirements for agents. At a minimum, agents should be thoroughly familiar with the Medicare program—its benefits and limitations—and the insurance packages they are marketing to the public. The state could administer an examination to test the proficiency of each agent before licensing.
- Enact legislation making an insurance agent a fiduciary. Agents could also be bonded to sell certain kinds of insurance.
- Limit commissions paid to agents or restructure the commission schedule to eliminate the large differential between the commissions paid for new insurance and those for renewed policies.
- Restrict the licensing of an agent if his license has been revoked or suspended in another state.
- Make it a felony for a person to sell insurance after his license has been revoked or suspended.
- Limit the number of companies an agent can represent.
- Require agents to make personal restitution to policyholders if convicted of fraudulent marketing practices.

5. Consumer Information and Disclosure

Without an informed public, other actions taken by states to curb abuses in the sale of private health insurance cannot be truly effective. Providing those over 65 with meaningful, useful information about their insurance needs and the insurance marketplace is not an easy proposition. Many states, however, realizing the importance of good consumer information programs and disclosure requirements, have been moving to institute necessary reforms in this area. Some suggestions for state action include:

- Establish a counselling program for the elderly through existing private and public sector organizations. Personal, accessible assistance to the elderly on insurance matters is essential to successfully helping those over 65 with their insurance needs and problems.
- Develop and provide a consumer information pamphlet which discusses Medicare and all kinds of private health insurance sold to the elderly. Many states (including Wisconsin, New Jersey, New York, Kansas) and the NAIC, already have developed such an informational brochure. To be most effective, each senior citizen who buys a new policy should be given a pamphlet *at the time of purchase.*
- Provide information to senior citizens on the performance of individual insurance companies (i.e., loss ratios of policies, claims handling experience, denial rates, and complaint handling). If possible, this information should also include an overall cost indexing of insurance policies and a ranking of insurance companies based on performance. A simple, overall performance indicator would be most helpful to the prospective purchaser in evaluating and comparing various companies.
- Provide information to senior citizens on the risk factors for those over 65 (i.e., frequency of illness by disease category, frequency of hospitalization, average length of stay in a hospital, average cost of treatment, etc.). This kind of information might make the more limited policies and first dollar coverage less attractive to those shopping for insurance.
- Mandate the use of a disclosure form at the time a policy is purchased which details what Medicare pays, what the policy pays, and the policyholder's out-of-pocket expense. Disclosure forms should also be used when indemnity and dread disease policies are purchased.
- Include a warning on the disclosure form regarding the dangers of cancelling policies currently in force.
- Include the name of a company's general agent (other than the agent selling the policy) on the disclosure form.
- Make sure policyholders know how to contact the insurance company and the state insurance department, preferably through a toll free telephone number.
- Require all policies to be clearly labeled as a Medicare supplement, limited, or dread disease policy or indicate that a policy is or is not a Medicare supplement.
- Make sure the elderly are fully aware of the premium amount, whether it rises with age, and if it can be changed at the discretion of the insurance company.



VIII. THE FEDERAL GOVERNMENT AND MEDIGAP: AN UPDATE

Although many states are making progress in instituting reforms to deal with Medigap problems, the federal government is maintaining an active interest in this important issue. In fact, federal involvement in the private health insurance marketplace remains a distinct possibility. Both the Senate Finance Committee and the Ways and Means Committee in the House have recently adopted Medigap related amendments to various bills. The amendments, if finally considered and approved by the full House and Senate, would directly involve the federal government in the regulation of the insurance industry for the first time. They would establish a voluntary certification program for policies supplementing Medicare, set penalties for agent misrepresentation, and require some basic disclosure requirements. Final resolution of these amendments remains in doubt, especially this year, but it illustrates the proclivity of Congress to begin to "move" on this issue. In any event, Congress, DHEW, and the FTC are all continuing to explore and test ways to ameliorate Medigap abuses.

Those supporting increased federal government regulation of the private health insurance marketplace cite a number of reasons for their views. As noted in the final report of the Select Committee on Aging, these reasons include:[49]

1. Not enough states have taken specific, comprehensive legislative and regulatory steps to curb Medigap problems. Since states have not taken strong measures, individually and as a whole, the federal government must step in to protect the nation's senior citizens from further abuse.
2. Most of the problems arising from the sale of Medicare supplements and other forms of insurance sold to the elderly are a direct result of the confusing, inequitable, and poorly designed nature of the Medicare program. Therefore, the federal government must assume the primary responsibility for the problems associated with the sale of private health insurance, and move to alleviate these problems.
3. The public would benefit from the standardization of policies and benefits throughout the country, which could only be accomplished by federal intervention and regulation. Depending upon the degree of federal regulation of the insurance industry, people moving from state to state would be assured of policy, benefits, and regulatory continuity. For example, definitions of terms used in insurance policies could be standardized. Proponents also argue that standardization of policies, etc., would make it easier (and cheaper) for private insurers to design and market their products in various states. A policy would not have to be modified 50 times to conform to individual state laws.
4. Finally, since the federal government has jurisdiction over the mails, only the federal government is capable of regulating mail order insurers. They could move to eliminate mail order abuses, including problems with insurance trusts and unlicensed out-of-state insurers which currently successfully evade state regulatory efforts.

Many options are available to federal policymakers should they decide to take action on Medigap. For example, they could take limited action specifically targeted at one aspect of marketing problem (e.g., mail order of insurance trusts). Other, more comprehensive initiatives include restricting Medicare's benefit provisions to reduce coinsurance and deductible requirements, or offering a Medicare supplement program through the federal government. Often referred to as a possible Part C of Medicare, this last option could make coverage available to Medicare eligibles for services not currently provided by private insurers (e.g., eye exams, physicals).

The Department of Health, Education and Welfare is increasing its efforts to inform and educate the elderly consumer. As noted, DHEW, through the Health Care Finance Administration, has worked closely with the NAIC in developing a "Consumers Guide" for senior citizens. HCFA officials will soon send out a notice to all Social Security bene-

ficiaries advising them about Medigap problems and the availability of the informational booklet. DHEW is also devising a series of public service announcements that will attempt to inform senior citizens about their health insurance needs. DHEW's Administration of Aging (AoA) is also involved in Medigap and attempting to upgrade and expand senior citizens' counseling services. Under a grant from the AoA, American University's School of Government and Public Administration is conducting a study of Medicare supplements and an evaluation of their cost-effectiveness.

The Federal Trade Commission (FTC) is also continuing to study the marketing of Medicare supplements. The FTC's Commissioner Dole, in testimony before the Senate Special Committee on Aging in June of 1978, recommended that the FTC, DHEW, and the National Association of Insurance Commissioners join to conduct an impact evaluation of effectiveness of state regulations of Medicare supplement insurance. This same recommendation was contained in the 1978 report on Medicare supplements released by the FTC. To prepare for the more comprehensive impact evaluation, the FTC is currently involved in a pilot research study (RFP No FTC-9-78). The study is designed to "obtain basic facts about the insurance industry—what policies are sold to the elderly and what gaps they fill, and to design and pre-test a questionnaire for use in personal interviews of coinsurers of Medicare supplement insurance. Officials at the FTC report the pilot study is nearing completion and should be available towards the end of 1979.

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[2] U.S. Congress, House, Select Committee on Aging, Prepared Statement by Elizabeth Hanford Dole, Commissioner, Federal Trade Commission, *Abuses in the Sale of Health Insurance to the Elderly, Hearing Before the Select Committee on Aging.* 95th Congress, 2nd session, 1979, p. 141.

[3] U.S. Congress, House, Select Committee on Aging, *Abuses in the Sale of Health Insurance to the Elderly in Supplementation of Medicare; A National Scandal, A Staff Study by the Select Committee on Aging.* 95th Congress, 2nd session, 1978, p. 7.

[4] *Abuses in the Sale of Health Insurance, Hearing; op cit.,* supra note 2; statement by Dole, p. 141.

[5] *Abuses in the Sale of Health Insurance; A National Scandal; op cit.,* supra note 3; p. 3.

[6] *Ibid.,* pp. 9 and 11.

[7] Table 1 is compiled from several sources including a similar table contained in the study by Ann Denovo and Gail Shearer, for the Federal Trade Commission's Office of Policy Planning, *Private Health Insurance to Supplement Medicare,* Volume II - Appendixes, July, 1978.

[8] *Abuses in the Sale of Health Insurance: A National Scandal, op cit.,* supra note 3; p. 6.

[9] *Medicare Gaps and Limitations; op cit.,* supra note 1; pp. 49-50; and U.S. Department of Health, Education, and Welfare, Social Security Administration, *Your Medicare Handbook,* 1978.

[10] U.S. Department of Health, Education and Welfare, Social Security Administration, *Monthly Benefit Statistics,* No. 10, Sept. 7, 1979.

[11] *Abuses in the Sale of Health Insurance, Hearing; op cit.,* supra note 2; statement by Val J. Halamandaris, p. 130.

[12] *Ibid.*

[13] *Ibid.,* statement by Dole, p. 141.

[14] *Private Health Insurance to Supplement Medicare; op cit.,* supra note 7; Vol. I, July 1978, p. 8; and Footnote no. 23, p. 4, (Original Source - *The Washington Post,* February 11, 1978, p. 1).

[15] *Abuses in the Sale of Health Insurance: A National Scandal; op cit.,* supra note 3; p. 20.

[16] *Ibid.,* p. 21.

[17] U.S. Congress, Senate, *Medi-Gap: Private Health Insurance Supplements to Medicare, Hearing Before the Special Committee on Aging.* 95th Congress, 2nd session, Part 1, 1978, p. 2.

[18] *Ibid.,* p. 1.

[19] *Ibid.,* p. 92.

[20] U.S. Congress, House, *Hospital Cost Containment.* Subcommittee on Health, Committee on Ways and Means, and Subcommittee on Health and the Environment, Committee on Interstate and Foreign Commerce (Joint Committee Print), 1979, p. 3.

[21] U.S. Department of Commerce, Bureau of the Census, *Statistical Abstract of the United States: 1978,* p. 112.

[22] *Abuses in the Sale of Health Insurance: A National Scandal; op cit.,* supra note 3; p. 204.

[23] *Ibid.,* p. 212.

[24] *Ibid.,* p. 218.

[25] *Abuses in the Sale of Health Insurance, Hearing; op cit.,* supra note 2; p. 131.

[26] *Abuses in the Sale of Health Insurance: A National Scandal; op cit.,* supra note 3; p. 119.

[27] *Abuses in the Sale of Health Insurance, Hearing; op cit.,* supra note 2; p. 119.

[28] *Private Health Insurance to Supplement Medicare; op cit.,* supra note 7; Vol. 1, p. 23.

[29] *Abuses in the Sale of Health Insurance, Hearing; op cit.,* supra note 2; p. 3.

[30] *Ibid.,* pp. 10-11.

[31] *Ibid.,* Appendix I, pp. 151-180. (The insurance industry's position on loss ratios and how they are computed is discussed in some detail.)

[32] *Abuses in the Sale of Health Insurance: A National Scandal; op cit.,* supra note 3; p. 102.

[33] *Ibid.,* p. 105.

[34] *Abuses in the Sale of Health Insurance to the Elderly, Hearing; op cit.,* supra note 2; p. 85.

[35] *Abuses in the Sale of Health Insurance: A National Scandal; op cit.,* supra note 3; pp. 143-144.

[36] The Congressional staff made several attempts to document agent abuse in Pennsylvania, but found very little fraud. They attributed this excellent performance to actions taken by the state insurance commissioner, past and present, to crack down on agent abuse. See pages 173 and 174 of *Abuses in the Sale of Health Insurance: A National Scandal,* for full discussion.

[37] *Abuses in the Sale of Health Insurance, Hearing; op cit.,* supra note 2; pp. 131-132.

[38] *Ibid.,* p. 136.

[39] See the "Supplemental Statement of the National Association of Insurance Commissioners" contained in *Medi-Gap: Private Health Insurance Supplements to Medicare; op cit.,* supra note 17; pp. 257-260, for a more complete review of NAIC activities.

[40] *Ibid.,* p. 260.

[41] For the complete findings of the "Survey of the 50 State Departments of Insurance" conducted by the Staff of the Select Committee on Aging, see pages 251-306 in *Abuses in the Sale*

of *Health Insurance: A National Scandal; op cit.*, supra note 3.

[42] *Ibid.*, p. 327.

[43] *Medi-Gap: Private Health Insurance Supplements to Medicare; op cit.*, supra note 17; part 2, p. 261.

[44] Statement by Edward J. Birrane, Insurance Commissioner, State of Maryland, Appearing on Behalf of the NAIC Before the House Interstate and Foreign Commerce Committee, June 13, 1979, pp. 5-6.

[45] *Ibid.*, p. 5.

[46] State insurance officials often noted that it was hard to distinguish between "complaints" and "inquiries." As a rule, these officials felt both were increasing, especially the inquiries.

[47] The state of Vermont is in the process of drafting Medicare supplement regulations which should be adopted next year. State insurance officials indicate Vermont will use most of the NAIC's 1977 Individual Accident and Sickness Minimum Standards Act and the amendments to this act adopted by the NAIC in June of 1979. Officials believe the new regulations will be very comprehensive and will vary from and, in places, exceed NAIC model rules.

[48] New York's consumer information pamphlet "When Medicare is Not Enough" has just been completed and contains a rating and ranking of insurance policies sold to the elderly. John Dorfman, consultant to the New York State Consumer Protection Board (CPB) and the State Office on Aging, developed the methodology for the rating system which is also available from the CPB.

[49] *Abuses in the Sale of Health Insurance: A National Scandal; op cit.*, supra note 3; p. 319.

TABLE 4 SUMMARY OF SPECIFIC STATE LAWS AND REGULATIONS RE: MEDIGAP*

STATE	CITATION	EFFECTIVE DATE	TYPE OF POLICY AFFECTED	MINIMUM STANDARDS/ BENEFITS		
				MEDICARE SUPPLEMENT	HOSPITAL INDEMNITY	DREAD DISEASE
CALIFORNIA	CAC, Title 10, Art. 5, Secs.	11/4/72				
	2220.24 2220.29 2220.30			X	X	X
	CAC, Title 10, ART. 12.2, Sec. 2540	4/15/75 Amended 2/76	Individual, Family, Selected Group (Franchise), and Certificate			
	CAC, Title 10, Art. 1.5, Sec. 2220.29	5/1/78 (Minimum Benefits) 1/1/79 (Loss Ratio and Disclosure)		X	X	
COLORADO[1]	Regulation No. 76-6	7/1/77	Individual, direct response			
CONNECTICUT	P.A. 75-616 Ch. 692 Sec. 38-378	4/1/76	Individual (not including group conversion)	X	X	
	P.A. No. 79-289	10/1/79	Individual, Group Certificate, or Individual Subscriber Contract			
	Proposed Regs. 38-378(c)-5 to 12	N/A	Individual, Out-of-State (licensed in Connecticut)			
ILLINOIS[2]	P.A. 80-435 Sec. 363	1/1/78	Individual, Group	X		
	Sec. 363a	1/1/78	Individual, Group			

LOSS RATIO	DISCLOSURE REQUIREMENTS: Medicare Supplement	Hospital Indemnity	Dread Disease	Other	DREAD DISEASE POLICIES BANNED[8]	OTHER PROVISIONS[7]	
							-minimum standards later amended
	X	X	X	X			-establishes standard disclosure forms; also has forms for basic hospital, major medical, certificates and others
M/S 55%	X					**-establishes three ungraded classes of Medicare supplements: In-Hospital, In-Hospital and Out-of-Hospital, and Catastrophic**	-sets disclosure for three categories of Medicare supplements -allows for "Catastrophic Medicare supplement" coverage with minimum lifetime benefits of $25,000 and a maximum of $1,000 deductible -requires separate reporting of Medicare supplement loss experience
	X	X				-forms used when coverage would *add to* or replace existing insurance -used by agent at time of application, direct insurers must provide *before* policy is issued	-no specific chart comparing benefits included
				X	X	-classification of policies does not specifically mention Medicare supplements but includes various forms of hospital and medical policies -sets basic standards for content and use of outline of coverage	-authorizes commissioner to issue regulations to establish specific standards for benefits
Individual 65% Group 70%	X					-calls for full disclosure at time of application and authorizes development of regulations	
	X					-requires separate paragraph for pre-existing conditions -details contents of Medicare supplement disclosure form	-requires notice if policy would replace or add to existing coverage (separate forms for each occurrence)
							-affects *only* policies issued in Illinois
	X	X		X		-applies to health policies sold to Medicare eligibles; does not apply to dread disease	-provisions prohibit certain representations in advertising or by agents

TABLE 4 SUMMARY OF SPECIFIC STATE LAWS AND REGULATIONS RE: MEDIGAP*

STATE	CITATION	EFFECTIVE DATE	TYPE OF POLICY AFFECTED	Minimum Standards/ Benefits: MEDICARE SUPPLEMENT	HOSPITAL INDEMNITY	DREAD DISEASE
MASSACHU-SETTS	211 CMR 47.00	Filed September 17, 1979	Individual, and Non-Group Subscriber Contracts of Non-Profit Hospital, Medical, & Dental Service Corporations	X		
MICHIGAN	P.A. 447 of 1978 MIC. 2265 (See Bulletin 79-4)	4/1/79	Individual, Group, Out-of-State	X		
	R. 500.803					
MINNESOTA[3]	Minnesota Comprehensive Health Insurance Act of 1976 Secs. 62E.01 to 62E.17	7/1/76	Hospital, Medical, and Surgical Care Plans	X		
	Proposed Rules[4] Governing Minimum Anticipated Loss Ratios	N/A	Individual, Contract Group (partial)	X	X	
MONTANA	Montana Administrative Register, Page 1216	6/1/79	Individual, Out-of-State			

LOSS RATIO	Disclosure Requirements: Medicare Supplement	Hospital Indemnity	Dread Disease	Other	DREAD DISEASE POLICIES BANNED	OTHER PROVISIONS[7]	
65%	X			Disability Income		**-establishes three categories of Medicare supplements, each having mandatory standards and benefits which may not be modified. A Medicare supplement (1) is the low option insurance while the Medicare supplement (3) is the high option insurance** - requires Flesch test readability score of 50 or more -bans the sale of a dread disease policy by requiring any dread disease policy to have a maximum benefit of no less than $10,000 and provide benefits for *at least* twelve specific conditions, including all forms of cancer	-requires the use of a disclosure form (a policy summary) at the time of application -contains extensive provisions relating to the filing and revising of policy forms and the maintenance of an up-to-date rate manual. An actuarial memorandum is required with each rate filing -includes sections on standards for maintaining experience data
						-insurers offering hospital, medical, or surgical "expense incurred policies" *must* provide Medicare supplements to Medicare eligibles. Only those *not previously* insured are subject to six-month pre-x clause -applies to dread disease policies written on an expense incurred basis	-policy *may not* include a waiting period, exclude a specific disease or physical condition, and others -sets filing and data requirements for Medicare supplements on Form 79041 to certify compliance with Michigan regulations
65%							
						-insurer must offer a "qualified" Medicare supplement plan to all Medicare eligibles who apply	-sets up series of qualified plans including catastrophic protection
M/S 55-65% H/I 50-60% 65% Group	X	X		X		-establishes filing requirements for policy forms and rates	-also sets variable standards for medical expense and loss of income policies (new and old policies) -loss ratio *must* be disclosed (individual policies) at time of application
	X					-contains disclosure form and general information statement to be used no later than at time of delivery	-regulation is unclear about applicability to group coverage

TABLE 4 SUMMARY OF SPECIFIC STATE LAWS AND REGULATIONS RE: MEDIGAP*

STATE	CITATION	EFFECTIVE DATE	TYPE OF POLICY AFFECTED	Minimum Standards/ Benefits		
				MEDICARE SUPPLEMENT	HOSPITAL INDEMNITY	DREAD DISEASE
NEW JERSEY	Assembly, No. 1474	2/79	Individual	X		
	Assembly, No. 3008	8/6/79	Individual, Group (less than 50), Direct Insurers, Certificate	X		
	Proposed Rules[4] for Minimum Standards for Health Insurance	N/A	Individual, Direct Insurers	X	X	N/A
NEW MEXICO	Dept. of Insurance Reg., Art. 11, Chap. 58, Rule 4	11/28/77	Individual, Direct Insurer (licensed in New Mexico)			
NEW YORK	Amendments to Regulation 62	12/1/72 (Updated by Amendments)	Individual, Group, Franchise, Certificates	X	X	N/A
OHIO	Rule 3901-1-35	1/1/79	Individual			
OREGON	OAR Chap. 836 Division 52-105 & 52-110	3/1/77	Individual, Group			
	Senate Bill 855	7/79				

LOSS RATIO	Disclosure Requirements: Medicare Supplement	Disclosure Requirements: Hospital Indemnity	Disclosure Requirements: Dread Disease	Disclosure Requirements: Other	DREAD DISEASE POLICIES BANNED	OTHER PROVISIONS[7]	
	X					-basic enabling legislation to establish minimum standards, including standards for full and fair disclosure. Authorizes Commissioner of Insurance to issue regulations	
						-establishes minimum standards for *language* used in policies	-minimum Flesch reading test score of 40, and methods to compute and measure policy readability
65% for over 65 coverage 55% for most other policies	X	X	N/A	X		-contains section on policy definitions, prohibited policy provisions or coverages, minimum standards for benefits, applications, disclosure provisions, and form submission requirements	-has separate disclosure forms for Medicare eligibles in most insurance categories -has separate notice to applicant in case of addition or replacement of insurance
	X					-disclosure form used no later than at delivery	-contains text of regulation and disclosure form
60% for those 60+ 65% (for Groups of Over 50)		X	N/A	X		-minimum standards for the form, content, and sale of health insurance, including full disclosure -extensive procedures and requirements for filing of rates and standards for maintaining experience data	-Medicare supplement disclosure requirements under basic hospital, hospital and medical, and major medical categories
	X					-prohibits unfair and deceptive practices by agents and insurers—especially implying government affiliation	
	X					-unspecific about applicability to mail order	-form due no later than delivery
60%						-authorizes Commissioner to establish minimum benefit standards and to discourage duplication and replacement of coverage	

TABLE 4 SUMMARY OF SPECIFIC STATE LAWS AND REGULATIONS RE: MEDIGAP*

STATE	CITATION	EFFECTIVE DATE	TYPE OF POLICY AFFECTED	Minimum Standards/ Benefits: MEDICARE SUPPLEMENT	HOSPITAL INDEMNITY	DREAD DISEASE
PENNSYLVANIA[5]	P.L. 123, No. 54	5/18/76	Individual, Subscriber Contracts, Non-Profit Health Service Plans, and Certificates issued by Fraternal Benefit Societies	X		
SOUTH DAKOTA	Chap. 20:06:13	10/1/79	Individual, Group, Direct Insurers			
UTAH[6]	HB 187 Sec. 31-44-1 to 31-44-8	1979	Individual, Subscriber Contracts	X	X	X
WASHINGTON	WAC 284-50 450,455, 460,465	4/20/78	Individual, Contract			
WISCONSIN	Ins. 3.39	11/29/77	Individual	X		

Table 4 Footnotes

* Other states not included in this list do have general health insurance regulations (e.g., New Hampshire, Texas) which affect the sale of Medicare supplements.

[1] Colorado has other regulations which affect Medicare supplements including a 60% loss ratio which are not indicated in this chart.

[2] Revisions to Sec. 363 and 363a have been developed and should be acted upon early next year. (See narrative)

[3] The law covers all types of health insurance, only the provisions affecting Medicare supplements are noted in this chart.

[4] Rules have not yet been adopted.

[5] Regulations to implement minimum standards have been promulgated but were not available by date of printing. Basically they

LOSS RATIO	Disclosure Requirements: Medicare Supplement	Hospital Indemnity	Dread Disease	Other	DREAD DISEASE POLICIES BANNED	OTHER PROVISIONS[7]	
	X					-directs Commissioner to issue minimum standards for full disclosure, benefits, and methods of identifying policies	-sets out contents of outline of coverage
	X					-form provided on or before delivery of policy -notes difference between approved and actual charges	-form stresses limitations of Medicare program by underlining phrases such as *Medicare approved*
	X			X		Commissioner may develop Buyers Guide for Medicare supplements -set standards for outline of coverage	-directs and authorizes Commissioner to set minimum policy standards and specific standards for benefits
	X					-contains advice not to purchase Medicare supplements if Medicaid eligible -specifies premium cost -commissioner's suggestions *precede* chart	-required at delivery -some services *never* covered by Medicare are listed
	X	X	X	X		**-establishes 4 categories of Medicare Supplements (1 through 4-A & 4-B), each with a minimum set of benefits** -policy designation (labeling) in 18 point type	-nursing home coverage must apply to *all* nursing facilities—even those *not* Medicare approved -buyers guide and outline of coverage must be given to applicant at time of application -hospital indemnity, dread disease, and nursing home policies must include notice that they are not Medicare supplements
	(Separate disclosure form for *each category* of Medicare supplement)						

require any policy sold as a Medicare supplement to *fully* cover the "gaps" in Medicare coverage.

[6] Specifically directs Commissioner to develop disclosure requirements for Medicare supplements and *allows* disclosure for other kinds of policies.

[7] "Other Provisions": miscellaneous provisions of law which may be significant or of interest. The listing is not all-inclusive.

[8] New Hampshire also has a regulation which effectively bans the individual sale of dread disease policies. Dread disease coverage may be obtained as a rider to another health insurance policy.

TABLE 5 VIEWS OF STATE INSURANCE OFFICIALS REGARDING MEDIGAP[1]

STATE	ASSESSMENT OF PROBLEMS			REASONS CITED FOR MEDIGAP PROBLEMS				TYPES OF POLICIES CAUSING MOST PROBLEMS				PROBLEMS IN PROSECUTING ABUSE			
	MEDIGAP IS MAJOR PROBLEM[2]	IMPROVING	SAME OR WORSE[3]	CONSUMER INFORMATION	AGENT PRACTICES[4]	CLAIMS PAYMENT/SERVICE	POLICY FORMS	OTHER	MEDICARE SUPPLEMENT	HOSPITAL INDEMNITY	DREAD DISEASE	SAME	MAIL ORDER INSURANCE PROBLEMS[5]	LACK OF PERSONNEL	CAPABLE AND WILLING WITNESSES	INADEQUATE LAWS
ALABAMA			X			X						X				
ARIZONA		X			X		X					X	X			
ARKANSAS		X		X				UCR				X				
COLORADO	X	X				X			X						X	
CONNECTICUT	X		X		X					X			X		X	
DELAWARE			X									X				
FLORIDA		X		X	X					X	X		X	X		
GEORGIA		X			X				X					X	X	
IDAHO	X		X		X							X	X	X		
ILLINOIS	X		X		X									X	X	
IOWA			X	X	X			X	(SNF)	N/A				X	X	
KANSAS		X			X		X					X			X	
KENTUCKY	X	X		X	X							X	X	X		
MAINE			X		X							X	X	X	X	
MASSACHUSETTS	N/A[6]	N/A		X								X	N/A	N/A	N/A	
MICHIGAN			X		X					X	X		X		X	
MISSISSIPPI			X	X	X							X	X	X		
MISSOURI			X	X	X			UCR	X							
MONTANA			X						X							
NEBRASKA	X		X			X			X							X
NEVADA		X		X				UCR				X	X			
NEW HAMPSHIRE		X				X				X						
NEW JERSEY	X	X				X			X	X			X	X		X
NEW MEXICO		X		X				X	X				X	X	X	
NEW YORK			X	X	X			Pre-X		X			X			
NORTH CAROLINA			X	X	X				X							
NORTH DAKOTA	X		X	X	X				(SNF)					X		X
OHIO	X		X			X		Pre-X	(SNF)					X		
OKLAHOMA		X		X	X					X						
OREGON	X	X			X						X		X			
PENNSYLVANIA		X		X	X							X	X	X	X	
RHODE ISLAND			X	X							X			X	X	X
SOUTH CAROLINA	X		X		X			X	X				X			
SOUTH DAKOTA			X		X				X						X	
TENNESSEE		X		X	X				X				X		X	
TEXAS			X	X		X			X					X		
UTAH	X		X	X	X					X	X					
VERMONT	X		X		X				(SNF)	X	X		X		X	
VIRGINIA			X	X	X				X							
WASHINGTON		X		X								X	X		X	
WEST VIRGINIA	X		X	X	X				X				X	X		
WYOMING	X		X		X							X				
Total	15	16	25	21	27	7	2	8	18	9	6	14	19	16	15	4

Footnotes

1 The survey was conducted from May through part of August by telephone and, in some cases, by written response. Eight states are not included in the chart for various reasons: California and Wisconsin were contacted, but many of the questions (because of their advanced stages of rule-making) were not applicable to these states. Alaska, Hawaii, Louisiana, Maryland and Minnesota were not included because of unique insurance laws or because no response could be obtained.

2 Arkansas, Mississippi, Oklahoma, Texas and Washington all indicated the sale of private health insurance was a "serious" or "continuing" problem but did not want to classify the problem as "major."

3 Most states indicating an improvement in their medigap problem attribute better consumer awareness, disclosure, and strong action against agents as the primary reasons for the reduction of problems.

4 Agent practices includes a wide range of common abuses such as overselling, rolling over, agent misrepresentation, and high-pressure selling techniques.

5 Most states, because of prefiling provisions for advertising and forms and stricter advertising regulations (often noting the used of NAIC model regulations), don't seem to have much of a problem with direct insurers. However, almost *all* states indicated continuing problems with insurance trusts and out-of-state insurers not licensed to do business in that state.

6 N/A means no answer.

TABLE 6
ANTICIPATED CHANGES IN MEDIGAP REGULATION
(SURVEY OF STATE INSURANCE OFFICIALS)

STATE	STATES EXPECTING STATUTORY/ REGULATORY CHANGES IN NEAR FUTURE[1]		TYPES OF CHANGES EXPECTED[2]							DISCLOSURE IMPROVEMENT ACTIVITIES				
										CONSUMER PAMPHLET		COMPARISON FORM		
	LAW	REGULATION	CAN'T SAY	STANDARDIZATION	LOSS RATIO	MINIMUM BENEFITS	PRE-X CLAUSES/ WAITING PERIODS	COMPLAINT MONITORING	AVAILABLE	DRAFTING	AVAILABLE	DRAFTING[3]	TOLL FREE NUMBER[4]
Alabama		Minor											
Arizona	Significant												
Arkansas		Minor		X	X	X			X				X
Colorado			X	X	X					X	X		
Connecticut		Significant		X	X	X	X				X		X
Delaware	X	X								X			X
Florida		Significant		X	X	X	X	X		X		X	
Georgia		Significant		X	X		X	X		X			
Idaho													
Illinois	Significant			X					X			X	
Iowa	Significant	Significant			X	X	X	X					
Kansas			X		X		X	X	X				X
Kentucky		Significant							X			X	X
Maine									X				Will
Massachusetts		X		X	X	X	X						
Michigan				X				X	X				X
Mississippi			X		D/K[5]								X
Missouri			X						X				X
Montana									X		X		X
Nebraska	X	X							X				
Nevada		Minor			X	X							
New Hampshire		Significant		X					X		X		X
New Jersey		Significant							X		X		
New Mexico		Minor		X							X		
New York		Minor		X	X	X	X		X				X
North Carolina		X		X		X				X	X		
North Dakota				X	X	X				X		X	
Ohio			X		D/K				X			X	X
Oklahoma	Minor			X			X		X		X		
Oregon		Minor		X	X						X		X
Pennsylvania										X	X		X
Rhode Island			X	X		X	X					X	
South Carolina		Significant		X	X								
South Dakota			X		D/K						X		X
Tennessee	Significant	Significant		X	X	X			X				X
Texas		X									X		
Utah		Significant						X					
Vermont				X	X	X	X	X					
Virginia	Significant	Significant			X	X	X						X
Washington													X
West Virginia		Significant		X	X	X	X	X				X	X
Wyoming			X	X	X	X	X	X					
TOTAL	8	23	8	21	18	15	13	8	16	7	12	7	18

FOOTNOTES

[1] An X signifies some change is expected but no determination could be made as to the magnitude of the anticipated change.

[2] Many other changes other than those listed are possible; also, it should be remembered that individuals, for the most part, were speaking for themselves—their views *did not* necessarily reflect the policies or anticipated changes advocated by the commissioner of Insurance.

[3] Most pamphlets either currently available or in the drafting stages are *not* specifically designed for use by senior citizens. Usually, these pamphlets are for general distribution, not mandatory during the sale of Medicare supplements.

[4] The total free numbers indicated are, in some cases, not strictly for the use of senior citizens. Statewide "hot lines" to the governors' offices or other major offices/agencies are often used as to screen calls and transfer them to the appropriate state officials.

[5] D/K means Don't Know

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